

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 m / be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03986						03982					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			ALLEGANY			a. STATE			MARYLAND		
			MARYLAND			b. COUNTY			ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			CUMBERLAND			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			CUMBERLAND		
c. LENGTH OF STAY IN lb			10 DAYS			d. STREET ADDRESS			CASH BALLEY ROAD, RT. #1 BOX 647		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES											
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
PEARL		F.		ALBRIGHT		APRIL		29,		19 62	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		MARCH 1, 1889		73 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
HOUSEWIFE			OWN HOME			WEST VIRGINIA			U. S. A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
GRANT CHEOISTER						SUSIE WOTRING					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT					
NO			NONE			MEMORIAL HOSPITAL - CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						10 days					
420.0 DUE TO						Pulmonary Infarction, Possible Myocardial Infarction					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) DUE TO					
						Pneumonia, rt. lung + congestive Heart Failure					
						(c) DUE TO					
						Arteriosclerotic Heart Disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Fracture, left hip, 29 March, 1962.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year						20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19						While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from April 17, 1962, to April 29, 1962, that (I) (we) last saw the deceased alive on April 28, 1962, and that death occurred at 9:35 A.M. from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
DR. WYAND F. DOERNER						414 N. MECHANIC ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
BURIAL			MAY 1, 1962			GREENMOUNT CEMETERY			CUMBERLAND, MD.		
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS			25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
BYRON KIGHT						CUMBERLAND, MD.			DATE MAY 3 '62 Arthur S. Kraus		

(M)

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ALLIANCE

ALLIANCE

NUMBER 10

10 DAYS

MEMORIAL HOSPITAL  
GENERAL & SURGICAL WINGS

OVERLAND  
CASH BILLY ROAD  
AT 33 BOX DAY

PEARL

ALBRIGHT

APRIL

23, 1902

WHITE

MARCH 1, 1902

WEST VIRGINIA

U. S. A.

GRANT CHESTER

SUE WOTING

MEMORIAL HOSPITAL - CLEVELAND, OH.

*[Faint, illegible handwritten text]*

DR. WYAND T. DOERMER

DR. H. J. MCNEILL ST. CLEVELAND, OH.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. AISME  
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>						c. LENGTH OF STAY IN TB <b>Rural of Cumberland, Maryland</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Memorial Hospital</b>						d. STREET ADDRESS <b>293 National Highway, La Vale, Md.</b>					
3. NAME OF DECEASED (Type or print) <b>Thomas Trouton Anderson</b>						4. DATE OF DEATH <b>April 15 19 62</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/11/1909</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hercules Powder Co.</b>				11. BIRTHPLACE (State or foreign country) <b>Ocean, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>John R. Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Trouton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>W.W. II 214-05-8821</b>				17. INFORMANT <b>Miss Janet Anderson 293 National Hwy. La Vale</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420-1</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>-----</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>4/18/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR <b>John J. Hafer, Cumberland, Maryland</b>						24a. REC'D BY REGISTRAR <b>APR 18 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hafer</b>			

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**FOR STATE**  
**HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**03988 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**03984**

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>D O A</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>ROUTE 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LESLIE</b> Middle <b>I.</b> Last <b>ASHBY</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>23</b> , Year <b>19 62</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 25, 1913</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LASHLEY MASONRY INC.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT ASHBY</b>				14. MOTHER'S MAIDEN NAME <b>ETHEL GNEGY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-18-2282</b>		17. INFORMANT <b>MRS. BLANCHE ASHBY, FROSTBURG, MD. RT. 1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CRUSHED CHEST</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>(TRACTOR OVERTURNED)</b> (c) <b>91213</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>CATERPILLAR TRACTOR OVERTURNED WHILE BEING LOADED ON TRUCK</b>				INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>			
20a. TIME OF INJURY Month, Day, Year <b>11:40 a.m. Apr. 23 1962</b>		20b. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>SUNSET VIEW</b>		20f. (City or town) (County) (State) <b>CUMBERLAND, ALLEG., MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M. D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4/23/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-26-1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL PARK</b>		22d. LOCATION (City, town, or country) (State) <b>CUMBERLAND, MD.</b>	
23. FUNERAL DIRECTOR <b>J. P. Ours</b>				24a. REC'D BY REGISTRAR <b>APR 27 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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FOR STATE  
HEALTH DEPT.  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
03989														
03985														
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D. O. A. Memorial Hosp.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Potomac Park, Cumberland,</b> d. STREET ADDRESS <b>50 Pershing Dr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>LORA</b> Middle <b>GRACE</b> Last <b>AUMAN</b>					4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1962</b>									
5. SEX <b>Female,</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1900</b>		9. AGE (in years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR: Months <b>17</b> Days <b>19</b> IF UNDER 24 HRS.: Hours <b>19</b> Mins. <b>62</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife,</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>			11. BIRTHPLACE (State or foreign country) <b>Burning Spring, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>						
13. FATHER'S NAME <b>Philip H. Devine</b>					14. MOTHER'S MAIDEN NAME <b>Alice E. Bennington</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT Address <b>50 Pershing Dr.</b> <b>Mr. Loy E. Auman Potomac Pk. Cumb. Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 17, 1962</b> ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b> Address (Street, city, town, or county) <b>R9 Cumberland, Md.</b>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/20/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			22d. LOCATION (City, town, or country) (State) <b>Cumberland, Maryland</b>							
23. FUNERAL DIRECTOR ADDRESS <b>Charles L. George Cumberland, Md.</b>					24a. REC'D BY REGISTRAR DATE <b>APR 23 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Huns</b>							

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1. The first group of respondents (10%) was composed of individuals who had been employed by the company for less than one year. This group was the least experienced and the least likely to have been involved in the company's history.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03990

## CERTIFICATE OF DEATH

Reg. Dist. No. 03986

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>520 Forster Ave.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>ELIZABETH</b> Last <b>BERGMAN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1893</b>	9. AGE (In years last birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Loibel</b>				14. MOTHER'S MAIDEN NAME <b>Christine Fisher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. S. Harry Bergman</b> Address <b>Cumb. Md. 520 Forster Ave.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>Essential Hypertension</b> <b>12 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11 - 16, 19 50</b> , to <b>4 - 1</b> , 19 <b>62</b> that I last saw the deceased alive on <b>4 - 1</b> , 19 <b>62</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ralph W. Ballin</b>				ADDRESS (Street, city or town, state) <b>62 Greene St.,</b>		DATE SIGNED <b>4-2-62</b>	
PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin M.D.</b>				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/4/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul's</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 5 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

03300

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	
CITY		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF HEALTH		U.S. BUREAU OF VITAL STATISTICS	
WASHINGTON, D.C.		U.S. GOVERNMENT PRINTING OFFICE	
1930		1930	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03991						03987					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission)					
a. COUNTY <u>Allegany</u> MARYLAND						a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u>					
c. LENGTH OF STAY IN 1b <u>Life</u>						d. STREET ADDRESS <u>216 Cecelia Street</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>216 Cecelia Street</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Charles E. Billmyer</u>						4. DATE OF DEATH <u>Apr 7 1962</u>					
5. SEX <u>Male</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>Aug 30, 1892</u>					
9. AGE (In years last birthday) <u>69</u> yrs.						10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>					
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Foreman</u>						11b. KIND OF BUSINESS OR INDUSTRY <u>B+O P.R.</u>					
11c. BIRTHPLACE (County & State, or foreign country) <u>Cumberland Md</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					
13. FATHER'S NAME <u>Edward Billmyer</u>						14. MOTHER'S MAIDEN NAME <u>Mollie (Unknown)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>705-05-4814</u>					
17. INFORMANT <u>Mrs. C. E. Billmyer</u>						18. ADDRESS <u>Cumb. Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Cordial arrest</u>											
420.0 DUE TO <u>Congestive heart failure</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>A.S. heart disease with myocardial infarction</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>24 Dec 1946</u> to <u>7 Apr 1962</u> that (I) (we) last saw the deceased alive on <u>6 Apr 1962</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>W. Alfred Van Ormer</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10 Apr 62</u>											
22c. PHYSICIAN'S NAME (Type) <u>W. Alfred Van Ormer, M. D.</u> 22d. ADDRESS <u>122 South Centre St., Cumberland, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/10/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Cumberland Md</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md</u> 25a. REC'D BY REGISTRAR <u>APR 12 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>											

0393

19220

VR A15 (4  
15M 7/61

## 03988

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>		c. LENGTH OF STAY IN lb <b>67</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Barton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 36</b>		d. STREET ADDRESS <b>Route 36</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George Joseph Brennan</b>		4. DATE OF DEATH <b>April 6 1962</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1895 Feb. 15, 1962</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b>		11. IF UNDER 24 HRS. Hours <b>15</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tire Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto tire</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Barton-Allegany-Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward Brennan</b>		14. MOTHER'S MAIDEN NAME <b>Isabelle Brooks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-05241</b>		17. INFORMANT <b>Mrs. Virginia Brennan-Barton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-28-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <b>Coronary occlusion</b> <b>Coronary Sclerosis</b> DUE TO (c) <b>Emphysema + fibrosis pulmonary</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b> <b>15 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/1/1957</b> to <b>present date</b> , that (I) (we) last saw the deceased alive on <b>3/15/1962</b> , and that death occurred at <b>5 P.M.</b> , from the causes and on the date stated above		22a. SIGNATURE <b>Frank T. HARRAT</b> M.D.		22b. DATE SIGNED <b>4/17/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK T. HARRAT</b>		22d. ADDRESS <b>26 W. Mechanic St., Frostburg, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>4/9/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ed. B. B. L.</b> ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 11 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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Frank T. Hargrave

Frank T. Hargrave

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**MEDICAL CERTIFICATION**

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03993

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1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Allegany		Frostburg				Maryland		Allegany		Barton					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
Lawrence		H.		Broadwater				April		23		19		62	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		November 23, 1876		85		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Retired		Farmer		Garrett County Md.		U.S.A.									
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME											
Mortimer Broadwater				Ellen Magruder											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT							
								Ray Broadwater				Barton, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Cardio-vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Mar 9 1962 to April 23 1962 that (I) (we) last saw the deceased alive on Apr 22 1962 and that death occurred at 6 AM, from the causes and on the date stated above. 22a. SIGNATURE L. R. MILES, JR., M.D. 22c. PHYSICIAN'S NAME (Type) 22b. DATE SIGNED 4.23.62 22d. ADDRESS LONA CONING MD. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/25/62 23c. NAME OF CEMETERY OR CREMATORY Broadwater Cemetery 23d. LOCATION (City, town, or county) (State) Garrett County Md. 24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md. 25a. REC'D BY REGISTRAR DATE APR 24 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Frank															

STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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03990

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>10 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WARWICK &amp; MEMORIAL MEMORIAL HOSPITAL AVES.,</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLDTOWN, MARYLAND</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>JERIMIAH C. BROOKS</b>		<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>22</b> Year <b>1962</b>					
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>SEPT. 10, 1876</b>	<b>9. AGE</b> (In years and birthday) <b>85</b> yrs.         IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Fireman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Railroad</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WEST VIRGINIA-Slanesville S. A.</b>			
<b>13. FATHER'S NAME</b> <b>SILAS BROOKS</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH STEWART</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>705-12-2261</b>		<b>17. INFORMANT</b> Address <b>Mrs. Leoda Cage, Oldtown, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Uremic poisoning</b> DUE TO (c) <b>Generalized visceral failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>10 da.</b> <b>6 days</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Generalized arteriosclerosis, advanced age.</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>None</b> p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>None</b>		<b>20f. (City or town)</b> (County) (State) <b>April 12, 1962 to April 22, 1962</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>April 12, 1962</b> <b>to</b> <b>April 22, 1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>April 22, 1962</b> <b>and that death occurred at</b> <b>8:50 PM</b> <b>on the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>James F. Scarpelli</b>		<b>22b. DATE SIGNED</b> <b>4-23-62</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>DR. HALLINAN</b>			
<b>22d. ADDRESS</b> <b>140 BEDFORD STREET, CUMBERLAND, MD.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>Apr. 25, 1962</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oliver Grove Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Oldtown, Md.</b>				
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James F. Scarpelli, Cumberland, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 26 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles L. Thomas</b>			

MEMORIAL HOSPITAL

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ALLEGANY

CONFIDENTIAL

10 DAYS

OLDTOWN, MARYLAND

MEMORIAL HOSPITAL

AVENUE

MEMORIAL HOSPITAL

LEWIS

BROOKS

APRIL

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WHITE

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WEST VIRGINIA

ELIZABETH STEWART

ELIZABETH STEWART

DR. WILLIAM

120 E. 10th Street, Cumberland, Md.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03991

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Vale</b>		c. LENGTH OF STAY IN 1b <b>43 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Greenpoint</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Urner</b> Middle <b>Garfield</b> Last <b>Carl Sr.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 8, 1880</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Attorney At Law</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland, Md</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel A. Carl</b>		14. MOTHER'S MAIDEN NAME <b>Anna Sprenkle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Kathryn Frantz Carl</b>		Address <b>Greenpoint LaVale, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion</b> 4-22-62 DUE TO <b>Myocardial Infarct (Pulmonary)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Chronic Sclerotic Cardiovascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Fibrosis &amp; Emphysema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 years</b> <b>49 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>26 June 1962</b> to <b>31 March 1962</b> , that (I) (we) last saw the deceased alive on <b>31 March 1962</b> , and that death occurred on <b>30 April 1962</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>David T. Rees</b>		22b. DATE SIGNED <b>3 April</b>	
22c. PHYSICIAN'S NAME (Type) <b>David T. Rees, M.D.</b>		22d. ADDRESS <b>107 Montgomery Ave, Cumberland, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/4/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rosehill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	
ADDRESS <b>Cumberland Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>APR 5 '62</b>	

1997

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03996 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03992

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oldtown,</b> c. LENGTH OF STAY IN lb <b>Oldtown,</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Along State Rt. # 51</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oldtown,</b> d. STREET ADDRESS <b>Along State Rt. # 51</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LULA CORLIN CARTWRIGHT</b>		4. DATE OF DEATH <b>April 13, 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1887</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Okonoko, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank Gross</b>		14. MOTHER'S MAIDEN NAME <b>Emma Hudson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Gilbert Kline,</b>		Address <b>Oldtown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>coronary sclerosis</b> (c) <b>coronary sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>coronary occlusion</b> <b>coronary sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/16/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Cemetery,</b>		22d. LOCATION (City, town, or country) (State) <b>Oldtown, Maryland</b>	
23. FUNERAL DIRECTOR <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>Apr 17 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

Apr. 13, 1962  
DATE SIGNED

Rt. # 9  
Cumberland, Md.

SECRET

03002

1. copy



*Handwritten signature*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03997

## CERTIFICATE OF DEATH

Item 9 Film G311 1/19/62 mh

03993

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>6 WKS.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		d. STREET ADDRESS <b>15 LAING AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>PHILLIP COLOSIMO</b>		First		Middle <b>C</b>		Last <b>COLOSIMO</b>		4. DATE OF DEATH <b>APRIL 13 1962</b>		Month		Day		Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-18-11</b>		9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST HELPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>PHILLIP COLOSIMO</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH VINCENT</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>216-07-6512</b>		16. SOCIAL SECURITY NO. <b>PT'S CHART</b>		17. INFORMANT <b>Address</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) <b>163X</b>												INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>transverse myelitis due to metastatic carcinoma</b>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>3-10-1962 to 4-13-1962</b>		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-10-1962</b> to <b>4-13-1962</b> , that (I) (we) last saw the deceased alive on <b>4-13-1962</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.																	
22a. SIGNATURE <b>L. Brings MD</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-15-62</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. L. BRINGS</b>		22d. ADDRESS <b>57 GREENE STREET</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 4-16-62</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>St Michaels</b>		23d. LOCATION (City, town or county) <b>Frostburg Md.</b>		23e. (State) <b>Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Durst</b>		ADDRESS <b>Frostburg Md.</b>		25a. REC'D BY REGISTRAR <b>APR 17 '62</b>		25b. REGISTRAR'S SIGNATURE <b>C. H. S. HARRIS</b>	

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03993

03994

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN lb <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Memorial Hosp. (D. O. A.)</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>62 Cumberland Maryland.</b>			
3. NAME OF DECEASED (Type or print) <b>Clara A. Corbin</b>				d. STREET ADDRESS <b>#316 Maryland Ave.</b>			
5. SEX <b>Female</b>				6. COLOR OR RACE <b>White</b>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>6/26/83</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				11. BIRTHPLACE (State or foreign country) <b>Cumberland Md.</b>			
13. FATHER'S NAME <b>Hank Saville</b>				14. MOTHER'S MAIDEN NAME <b>Fanny Miller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>None</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-20-1</b> <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>CORONARY SCLEROSIS</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>SUDDEN</b>				17. INFORMANT <b>Husband Luther E Corbin Cumberland Md.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4/7/62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>				22d. LOCATION (City, town, or country) (State) <b>Cumberland Md.</b>			
23. FUNERAL DIRECTOR <b>Louis Stein Inc.</b>				24a. REC'D BY REGISTRAR <b>APR 9 '62</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Resort Hotel (L. A. A.)

310 310 Maryland Ave.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03995  
CERTIFICATE OF DEATH

03995

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> <u>ALLEGANY</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHIMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ECKHART</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LILLIAN</u> <u>M.</u> <u>CORDIAL</u>		First Middle Last		4. DATE OF DEATH <u>4</u> <u>28</u> <u>1962</u>		Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/13/92</u>		9. AGE (In years last birthday) <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN CRAWFORD</u>				14. MOTHER'S MAIDEN NAME <u>MALINDA CRAWFORD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>PAUL CORDIAL, CRESAP PARK, CUMBERLAND, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION &amp; AURICULAR FIBRILLATION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/5</u> , 19 <u>62</u> , to <u>4/28</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>4/14</u> , 19 <u>62</u> , and that death occurred at <u>7:25 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Leo H. Lye, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/28/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEO H. LYE, JR.</u>				22d. ADDRESS <u>456 N. CENTRE ST., CUMBERLAND, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-30-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHAEL'S CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>FROSTBURG, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. R. Burst</u>				ADDRESS <u>FROSTBURG, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 2 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

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03002

CERTIFICATE OF DEATH

03002

JOHN GRANT

JOHN GRANT

PAUL GRANT, GREAT LAKES CHURCH, MD.

WOMEN

JOHN GRANT, GREAT LAKES CHURCH, MD.

JOHN GRANT, GREAT LAKES CHURCH, MD.

JOHN GRANT, GREAT LAKES CHURCH, MD.

JOHN GRANT, GREAT LAKES CHURCH, MD.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
04000									
03996									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>82 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> <b>ALLEGANY</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MIDLAND</b> d. STREET ADDRESS <b>PARADISE ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>NETTIE</b>					4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>1962</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 29, 1877</b>		9. AGE (In years last birthday) <b>84</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID SUSLER (DECEASED)</b>					14. MOTHER'S MAIDEN NAME <b>NAOMI BEAVER (DECEASED)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>PATIENT'S CHART</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lower nephron nephrosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary arteriosclerosis, myocardial fibrosis</b> (c) <b>Coronary arteriosclerosis, myocardial fibrosis</b> DUE TO (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anuria Cardiac decompensation</b>								INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>???</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1/10/62</b> , 19 <b>62</b> to <b>4/3/</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>4/2/62</b> , 19 <b>62</b> , and that death occurred at <b>2:30</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Samuel M. Jacobson</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL M. JACOBSON</b>					22d. ADDRESS <b>50 PERSHING ST., CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Belvedere Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Midland, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b> ADDRESS <b>Lonaconing, Md.</b>					25a. REC'D BY REGISTRAR <b>APR 6 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		

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STATE OF TEXAS

COUNTY OF DALLAS

IN THE DISTRICT COURT OF THE

STATE OF TEXAS

IN RE: THE ESTATE OF

JOHN W. BROWN

DECEASED

VS.

JOHN W. BROWN

W. J. BROWN

George Brown

Donna Brown, Adm.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61

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04001

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kifer, Md.</b> c. LENGTH OF STAY IN 1b <b>70 years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Kifer, Md.</b> d. STREET ADDRESS <b>Rural Kifer, Md.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ellwood</b> First Middle Last		4. DATE OF DEATH <b>April 7, 1962</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1869</b> Yrs. Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	9. AGE (In years last birthday) <b>92</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Greenspring, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eli Crabtree</b>		14. MOTHER'S MAIDEN NAME <b>Margaret J. Robertson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Merlin O; Crabtree, Kifer, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis</b> (c) <b>Semileth</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semileth</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, specify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Dr. Brown</b> attended the deceased from <b>5/Jan/62</b> to <b>5/Jan/62</b> , 19 <b>62</b> that (I) <b>(we)</b> last saw the deceased alive on <b>5/Jan/62</b> , 19 <b>62</b> , and that death occurred <b>6A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Brown</b> NAME (Type) <b>J. D. Brown, MD</b>		22b. DATE SIGNED <b>9/Jan/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. D. Brown, MD</b>		22d. ADDRESS <b>Romney, W. Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/9/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sulphur Springs Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Kifer, Allegany Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>PARKS-JOHNSON Co.</b> ADDRESS <b>BERKELEY SPRINGS, W. Va.</b>		25a. REC'D BY REGISTRAR <b>APR 12 '62</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04002

03998

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (if outside corporate limits, write nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY in lb <b>6 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLDTOWN, MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>			d. STREET ADDRESS <b>Oldtown, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>LESSIE</b> Last <b>GRABTREE</b>			4. DATE OF DEATH Month <b>4</b> Day <b>5</b> Year <b>1962</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 8, 1893</b>	9. AGE (In years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>5</b> Hours <b>19</b> Min. <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>DECEASED</b>			14. MOTHER'S MAIDEN NAME <b>DECEASED</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>232-10-5631</b>		17. INFORMANT <b>CHART (PATIENT)</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>apoplectic stroke</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>cerebral embolism</b> (c) <b>rheumatic heart</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>8 days</b> <b>16 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic heart disease</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-31-62</b> to <b>4-5-62</b> , that (I) (we) last saw the deceased alive on <b>4-5-62</b> , and that death occurred at <b>8:35a</b> M., from the causes and on the date stated above.					
22a. SIGNATURE <b>L. Brings</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>April 7, 1962</b>
22c. PHYSICIAN'S NAME (Type) <b>DR. LEWIS BRINGS M. D.</b>			22d. ADDRESS <b>57 GREENE STREET CUMBERLAND, MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-8-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Methodist Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Oldtown, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>			25a. REC'D BY REGISTRAR DATE <b>APR 10 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

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John J. Hefner, Cambridge, Md.

Western Publishing Co.,

Chicago, Ill.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04003

## CERTIFICATE OF DEATH

Reg. Dist. No. 03999

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>10 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>29 Prospect Square</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>A.</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10th</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17th, 1909</u>
9. AGE (In years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Int. Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Decorating</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August H. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>113-01-9141</u>	
17. INFORMANT <u>John Davis, 20 Washington St., F'bg. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Insufficiency</u> (c) <u>Diabetes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis</u> <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5 months</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 29, 1962</u> , to <u>4/10, 1962</u> , that I last saw the deceased alive on <u>March 29, 1962</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. G. Weisman</u> M.D.		ADDRESS (Street, city or town, state) <u>59 Green St. Frostburg, Md.</u>	
DATE SIGNED <u>4/10/62</u>			
PHYSICIAN'S NAME (Type) <u>S. G. WEISMAN, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-12-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Evan. &amp; Ref. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Hurst</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 13 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04004										
01000										
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN lb <b>1 HR. 5 MIN.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			d. STREET ADDRESS <b>325 ARCH ST.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>BABY BOY DERLAN</b>					4. DATE OF DEATH Month Day Year <b>APRIL 17, 1962 19</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-17-62</b>		9. AGE (In years last birthday) yrs. Months Days <b>1 5</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>WILLIAM D. DERLAN</b>					14. MOTHER'S MAIDEN NAME <b>DOLLIE K. BEEMAN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory obstruction</b> DUE TO <b>762.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Massive fetal atelectasis, bilateral</b> (c) <b>Metabolic Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1hr-5min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>16 April 1962 to 16 April 1962</b>		20g. (County) <b>11:10 P.M.</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>16 April 1962</b> , that (I) (we) last saw the deceased alive on <b>16 April 1962</b> , and that death occurred at <b>11:10 P.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>Leland B. Ransom</b>					22b. ADDRESS <b>63 GREENE ST., CUMBERLAND, MD.</b>		22c. DATE SIGNED <b>4/19/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. LELAND B. RANSOM</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/19/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>					25a. REC'D BY REGISTRAR DATE <b>APR 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

2-065178

0004

0010

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

DECEASED

DATE OF BIRTH

SEX

365 ARCH ST.

CORAL HOSPITAL

APRIL 1, 1952

DECEASED

BOY

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WHITE

DECEASED, JR.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

04005

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04001

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Henry Care Home-715 Maryland Ave.</b>				d. STREET ADDRESS <b>217 Central Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Elizabeth</b> Last <b>Dorsey</b>				4. DATE OF DEATH Month <b>Apr.</b> Day <b>27</b> Year <b>1962</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 18, 1876</b>	
9. AGE (In years last birthday) <b>85</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>White Hall, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>David De Haven</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Whitacre</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Georgia Derrick, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Myocarditis; Acute Failure</b> 422- } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>--</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Apr. 30, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park Cumberland, Md.</b>	
23. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 1 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04001

04002



*Rembert H. Hester*



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> c. LENGTH OF STAY IN 1b <b>Miners Hospital</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b> d. STREET ADDRESS <b>High Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Calvin</b>		First <b>W.</b>		Middle <b>Duckworth</b>		Last <b>Duckworth</b>		4. DATE OF DEATH <b>April 17th.</b>		Month <b>19</b> Year <b>62</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 20. 1903</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Westernport, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Charles Duckworth</b>						14. MOTHER'S MAIDEN NAME <b>Annie Murphy</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>217-03-2041</b>		17. INFORMANT <b>Mrs. Daisy Duckworth, Lonaconing, MD.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma head of pancreas</b> (Wife) <b>157</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1961</b> to <b>April 17, 1962</b> , that (I) (we) last saw the deceased alive on <b>April 17, 1962</b> , and that death occurred at <b>6:00</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>L.R. Miles, Jr.</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-17-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>						22d. ADDRESS <b>LONA CONING MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<b>Burial</b>		<b>4/19/1962</b>		<b>Oak Hill Cemetery</b>		<b>Lonaconing, MD.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>				ADDRESS <b>LONA CONING, MD,</b>		25a. REC'D BY REGISTRAR <b>APR 19 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

04008

Allegany

Marshall

John Connelley

High Street

April 1903

Marshall

Oct. 20. 1903

U.S.A.

Marshall

Amie Murphy

217-02-3061 Mrs. Mary Jackson, Pennsylvania, Pa.

(Wife)

Wife

Marshall

Marshall

Marshall

Marshall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04007  
04003

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN lb <b>4 Weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS HOSPITAL</b>		d. STREET ADDRESS <b>262 W. MECHANIC STREET</b>	
3. NAME OF DECEASED (Type or print) <b>COBEY ENGLE</b>		4. DATE OF DEATH <b>APRIL 27TH, 1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 12TH, 1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUTCHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUTCHER</b>	9. AGE (In years last birthday) <b>61 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES ENGLE</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA HARDEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>MRS. MAE A. ENGLE, FROSTBURG, MD.</b>	
17. INFORMANT <b>MRS. MAE A. ENGLE, FROSTBURG, MD.</b>		Address <b>262 W. MECHANIC ST</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>550.1</b> DUE TO <b>Pneumonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Ruptured appendix above</b> <b>appendicitis chronic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>1 wk</b> <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 16 1962</b> to <b>April 27 1962</b> that (4) <b>(one)</b> last saw the deceased alive on <b>April 27 1962</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John B. Davis, M.D.</b>		22b. DATE SIGNED <b>4/30/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS,</b>		22d. ADDRESS <b>2 BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-30-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FB'G.MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Hurst</b>		24. ADDRESS <b>FROSTBURG, MD.</b>	
25a. REC'D BY REGISTRAR <b>DATE MAY 2 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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FOR STATE HEALTH DEPT. M  
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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**TITIAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday)		IF UNDER 1 YEAR	
IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET OF DEATH 30 Minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		22. LOCATION (City, town, or country) (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		24c. DATE	

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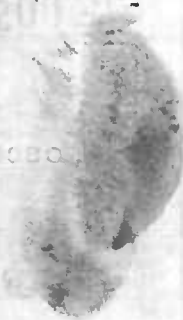
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MOSCOW</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Moscow</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Francis</b> Last <b>Fitzpatrick</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1894</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pekin, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Fitzpatrick</b>		14. MOTHER'S MAIDEN NAME <b>Bridget Monahan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Wm Fitzpatrick</b>		Address <b>Moscow, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis and Myocardial Degeneration not specified as Rheumatic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>422-2</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronchitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 10, 1957</b> to <b>Apr. 22, 1962</b> , that (I) (we) last saw the deceased alive on <b>Mar. 20, 1962</b> and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul R. Wilson</b>		22b. DATE <b>Apr. 23, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson M.D.</b>		22d. ADDRESS <b>111 Ashfield St. Piedmont, W. Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/25/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Gabriels Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Barton, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		25a. REC'D BY REGISTRAR <b>APR 27 '62</b>	
ADDRESS <b>Lonaconing, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Kline</b>	

1770

CERTIFICATE OF DEATH

1770



*[The following text is mirrored bleed-through from the reverse side of the page and is largely illegible due to fading and orientation.]*

George Johnson, deceased, was born on the 1st day of January, 1870, at the residence of his parents, John and Mary Johnson, in the town of ... State of ...

He was educated in the common schools of his native town and was employed as a ...

He was married to ... on the ... day of ... 1890, and they have ... children, ...

He died on the ... day of ... 1900, at the residence of his wife, ... aged ... years.

The cause of death was ...

Witness my hand and the seal of the Registrar of the County of ... this ... day of ... 1900.

Registrar of the County of ...

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS. A1SME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>824 Yale Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Clair Robert Flora</b>				4. DATE OF DEATH <b>April 18, 1962</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/26/1900</b>		9. AGE (In years last birthday) <b>61 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Dept.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>				11. BIRTHPLACE (State or foreign country) <b>Mahaffa, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Flora</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-05-6946</b>				17. INFORMANT <b>William Flora 916 Yale Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of Upper Abdomen</b> 976X DUE TO (b) <b>(Self Inflicted)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>20 Minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 18, 1962</b> DATE SIGNED BENEDICT SKITARELIC, M.D. Address (Street, city, town, or county) <b>R9 Cumberland, Md.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/20/1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Cumberland, Maryland</b>			
23. FUNERAL DIRECTOR <b>John J. Hafer Cumberland, Maryland</b>						24a. REC'D BY REGISTRAR DATE <b>APR 23 '62</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

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*Blanchet Blanche*

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Pages 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04011

04007

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>8 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>22 Frostburg</b> <b>135 Washington St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Katherine Cecelia Frankland</b>		4. DATE OF DEATH Month Day Year <b>April 16 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>Feb. 13, 1898</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Moran</b>		14. MOTHER'S MAIDEN NAME <b>Lucy B. Hershberger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Lawrence Blackburn-Piedmont, W. Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <b>90410 Contusions of Brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>(Fall at Home)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Uremia</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased Fell at Home</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>Apr. 5 1962; AM 1962</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <b>Home</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Frostburg, Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 16, 1962</b> Address (Street, city, town, or county) <b>B9 Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/19/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cem</b>		22d. LOCATION (City, town, or country) (State) <b>Westernport, Md.</b>	
23. FUNERAL DIRECTOR <b>El Bual</b>		ADDRESS <b>Westernport, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 17 1962</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 14 Film G312 5/12/62 mh

04009

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN lb <b>21 DAYS</b>		d. STREET ADDRESS <b>245 HUMBLD ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W.</b> Last <b>GLANTZER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>30</b> Year <b>1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-15-1867</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Planing Mill</b>	9. AGE (In years last birthday) <b>94</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>GLANTZER</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>220-10-0865</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>585x Sanguine of Spleen Bladder &amp; Lethargy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Uremia due to Sanguine</b> <b>Arteriosclerosis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wk.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> <b>2:40 P.M.</b> <b>1962</b> , 19...., that (I) (we) last saw the deceased alive on <b>April 30</b> , 19...., and that death occurred at <b>1962</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>DR. G. OVERTON HIMMELWRIGHT</b> M.D.		22b. ADDRESS <b>133 VIRGINIA AVE., CUMBERLAND, MD.</b>	
22c. PHYSICIAN'S NAME (Type)		22d. DATE SIGNED <b>5/3/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-3-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 8 '62</b> DATE <b>5/8/62</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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CUMBERLAND

GENERAL & WARREN AVE.  
GENERAL HOSPITAL

JOHN

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21 DAYS

GLANTZER

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CUMBERLAND

215 HARRIS ST.

APRIL 30

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CUMBERLAND, MD.

ALLERGY

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CUMBERLAND

STATE OF MARYLAND

133 VIRGINIA AVE., CUMBERLAND, MD.

DR. J. L. HARRIS

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04013

041008

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>7 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>R.F.D.#3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>RAY</b> <b>EX E.</b> <b>GLASS</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>19 62</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 22, 1889</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motel Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GLASS</b>				14. MOTHER'S MAIDEN NAME <b>HANNAH STONEBROOK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>208-09-7862</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4-20-62</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (b) <b>3 days</b> (c) <b>yes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 days</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 11, 1953</b> to <b>4/21, 1962</b> that (I) (we) last saw the deceased alive on <b>4/21, 1962</b> , and that death occurred <b>1:00 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George M. Simons</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE M. SIMONS</b>				22d. ADDRESS <b>ALGONQUIN HOTEL, CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/29/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Pleasant Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hennrietta Penna</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b> <b>Cumberland Maryland</b>				25a. REC'D BY REGISTRAR <b>APR 30 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	

04013

(14)

WILSON

MARYLAND

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CONGRESSIONAL

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CONGRESSIONAL

MEMORIAL HOSPITAL

R.F.D. 13

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HANNAH STONE

10-15

MEMORIAL HOSPITAL

CONGRESSIONAL

*George N. Simons*

GEORGE N. SIMONS

ALLEGANY HOTEL, CONGRESSIONAL

ALLEGANY HOTEL, CONGRESSIONAL

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Atlantic</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>8 Hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Atlantic City</b>				d. STREET ADDRESS <b>2710 Atlantic Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>16 Uhl Street</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>John Raymond Gormley</b>						4. DATE OF DEATH Month <b>Apr</b> Day <b>8</b> Year <b>1962</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 4th, 1904</b>		9. AGE (in years last birthday) <b>57 yrs.</b>		IF UNDER 1 YEAR Months <b>57</b> Days <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Funeral Director</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Undertaking</b>				11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John L. Gormley</b>						14. MOTHER'S MAIDEN NAME <b>Frances L. Brown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>						16. SOCIAL SECURITY NO. <b>155-03-2568</b>					
17. INFORMANT <b>Mrs. Irma W. Gormley</b>						Address <b>2710 Atlantic Ave., Atlantic City, N.J.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS WITH THROMBOSIS</b> (a), stating the underlying cause last. (c) <b>-----</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frostburg</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>W.O. McLane</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>W.O. McLane M.D.</b> and DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Frostburg, Md.</b> DATE SIGNED <b>Apr 9 1962</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4-12-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Memorial Park</b>				22d. LOCATION (City, town, or county) (State) <b>Pomona, N. J.</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Joseph R. D. ...</b>						24a. REC'D BY REGISTRAR DATE <b>4-9-1962</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. ...</b>		APR 12 '62	

U.S. DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01910

1000

1000

1. Name of Deceased	2. Sex	3. Age	4. Race
5. Date of Death	6. Time of Death	7. Place of Death	8. Cause of Death
9. Manner of Death	10. Signature of Examiner	11. Signature of Coroner	12. Signature of Medical Examiner
13. Signature of Physician	14. Signature of Nurse	15. Signature of Pathologist	16. Signature of Toxicologist
17. Signature of Forensic Pathologist	18. Signature of Forensic Toxicologist	19. Signature of Forensic Anthropologist	20. Signature of Forensic Entomologist
21. Signature of Forensic Radiologist	22. Signature of Forensic Microscopist	23. Signature of Forensic Chemist	24. Signature of Forensic Biologist
25. Signature of Forensic Geneticist	26. Signature of Forensic Immunologist	27. Signature of Forensic Microbiologist	28. Signature of Forensic Parasitologist
29. Signature of Forensic Plant Pathologist	30. Signature of Forensic Animal Pathologist	31. Signature of Forensic Fish Pathologist	32. Signature of Forensic Bird Pathologist
33. Signature of Forensic Mammal Pathologist	34. Signature of Forensic Reptile Pathologist	35. Signature of Forensic Amphibian Pathologist	36. Signature of Forensic Invertebrate Pathologist
37. Signature of Forensic Plant Pathologist	38. Signature of Forensic Animal Pathologist	39. Signature of Forensic Fish Pathologist	40. Signature of Forensic Bird Pathologist
41. Signature of Forensic Mammal Pathologist	42. Signature of Forensic Reptile Pathologist	43. Signature of Forensic Amphibian Pathologist	44. Signature of Forensic Invertebrate Pathologist
45. Signature of Forensic Plant Pathologist	46. Signature of Forensic Animal Pathologist	47. Signature of Forensic Fish Pathologist	48. Signature of Forensic Bird Pathologist
49. Signature of Forensic Mammal Pathologist	50. Signature of Forensic Reptile Pathologist	51. Signature of Forensic Amphibian Pathologist	52. Signature of Forensic Invertebrate Pathologist
53. Signature of Forensic Plant Pathologist	54. Signature of Forensic Animal Pathologist	55. Signature of Forensic Fish Pathologist	56. Signature of Forensic Bird Pathologist
57. Signature of Forensic Mammal Pathologist	58. Signature of Forensic Reptile Pathologist	59. Signature of Forensic Amphibian Pathologist	60. Signature of Forensic Invertebrate Pathologist
61. Signature of Forensic Plant Pathologist	62. Signature of Forensic Animal Pathologist	63. Signature of Forensic Fish Pathologist	64. Signature of Forensic Bird Pathologist
65. Signature of Forensic Mammal Pathologist	66. Signature of Forensic Reptile Pathologist	67. Signature of Forensic Amphibian Pathologist	68. Signature of Forensic Invertebrate Pathologist
69. Signature of Forensic Plant Pathologist	70. Signature of Forensic Animal Pathologist	71. Signature of Forensic Fish Pathologist	72. Signature of Forensic Bird Pathologist
73. Signature of Forensic Mammal Pathologist	74. Signature of Forensic Reptile Pathologist	75. Signature of Forensic Amphibian Pathologist	76. Signature of Forensic Invertebrate Pathologist
77. Signature of Forensic Plant Pathologist	78. Signature of Forensic Animal Pathologist	79. Signature of Forensic Fish Pathologist	80. Signature of Forensic Bird Pathologist
81. Signature of Forensic Mammal Pathologist	82. Signature of Forensic Reptile Pathologist	83. Signature of Forensic Amphibian Pathologist	84. Signature of Forensic Invertebrate Pathologist
85. Signature of Forensic Plant Pathologist	86. Signature of Forensic Animal Pathologist	87. Signature of Forensic Fish Pathologist	88. Signature of Forensic Bird Pathologist
89. Signature of Forensic Mammal Pathologist	90. Signature of Forensic Reptile Pathologist	91. Signature of Forensic Amphibian Pathologist	92. Signature of Forensic Invertebrate Pathologist
93. Signature of Forensic Plant Pathologist	94. Signature of Forensic Animal Pathologist	95. Signature of Forensic Fish Pathologist	96. Signature of Forensic Bird Pathologist
97. Signature of Forensic Mammal Pathologist	98. Signature of Forensic Reptile Pathologist	99. Signature of Forensic Amphibian Pathologist	100. Signature of Forensic Invertebrate Pathologist



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04015

04011

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>39 HRS. 50 MINS.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> <b>ALLEGANY</b> f. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FLINTSTONE</b> d. STREET ADDRESS <b>R.F.D.#2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ERNEST</b> Middle <b>JAY</b> Last <b>HAMILTON</b>				<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>28</b> Year <b>19 62</b>											
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>APRIL 1, 1892</b>									
<b>9. AGE</b> (In years last birthday) <b>70</b> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Farm</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>OLDTOWN, MARYLAND</b>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
	Hours														
	Min.														
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>FRANCIS HAMILTON</b>											
<b>14. MOTHER'S MAIDEN NAME</b> <b>LUCY MIDDLETON</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>											
<b>16. SOCIAL SECURITY NO.</b> <b>215-16-4342</b>				<b>17. INFORMANT</b> Address <b>MEMORIAL MARX HOSPITAL, CUMBERLAND, MD.</b>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> DUE TO <b>Hypertension</b> (b) <b>90% arteriosclerosis</b> (c) <b>goss. arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>4/26</b> , <b>1962</b> , <b>to</b> <b>4/28</b> , <b>1962</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>4/28</b> , <b>1962</b> , <b>and that death occurred</b> <b>9:55 A.M.</b> , <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <b>George M. Simons</b> M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>4/28/62</b>		<b>22b. DATE SIGNED</b>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>GEORGE M. SIMONS</b>				<b>22d. ADDRESS</b> <b>ALGONQUIN HOTEL, CUMBERLAND, MD.</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/30/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Herman Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Near Cumberland, Md.</b>									
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles L. George, Cumberland, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAY 1 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Thos. J. K...</b>									

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LEGACY

CONCEALING

MEMORIAL HOSPITAL

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WHITE

ESTER TERRY

FRANCES HILLTON

1935-1936

RYLAND

FLINTSTONE

R.F.D. 5

HILLTON

APRIL 1, 1935

CLOUTON, MARYLAND

LUCY MIDDLETON

MEMORIAL HOSPITAL, CONCORD, MD.

LEGACY

EREST

U.S.A.

LORE W. SIMONS

Mc. J. J. J. J. J.

Charles J. George

Charles J. George

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 2 Film 0311 4/25/62

04016

04012

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>PENNA.</b> b. COUNTY <b>Bedford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>11 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near CUMBERLAND, MARYLAND</b>			
f. STREET ADDRESS <b>RT.#3, BOX 410 HAZEN ROAD</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDWIN</b>		First <b>O. E.</b>		Middle <b>HARDINGER</b>		Last	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 25, 1885</b>	
9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. DATE OF DEATH <b>APRIL 16 1962</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Poultry Business</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>HIRAM HARDINGER</b>				14. MOTHER'S MAIDEN NAME <b>HESTER MC ELFISH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL</b>				Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Hemorrhage, recurrent, Cerebral Thrombosis with st. temp. 101.4, incomplete A.S. Vascular disease, ad. 1 year</b> 578X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gen. arteriosclerosis?</b> INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b> <b>14 days</b> <b>1 year</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5 a.m. 1962</b> to <b>10 a.m. 1962</b> ; that (I) (we) last saw the deceased alive on <b>26 a.m. 1962</b> , and that death occurred at <b>25 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Alfred Van Ormer</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>19 a.m. 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. A. VAN ORMER</b>				22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/19/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery Mausoleum</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Lee Silcox</b> Cumberland Maryland				25a. REC'D BY REGISTRAR DATE <b>APR 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	

04010

CERTIFICATE OF DEATH

04010



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
04017										
04013										
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>26 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b> d. STREET ADDRESS <b>241 ELDER STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>BESSIE F. HENDERSON</b>					4. DATE OF DEATH Month <b>APRIL</b> Day <b>23</b> Year <b>19 62</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 10, 1914</b> 47 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Operator</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home Laundry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND-CUMBERLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN HARE</b>					14. MOTHER'S MAIDEN NAME <b>EMMA BARGER</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO. <b>212-24-1188</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia &amp; bacteremia &amp; uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Wound description and infection</b> (a), stating the underlying cause last. DUE TO <b>Chronic cholecystitis with stones in common duct</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus, Hypertensive Cardio-vascular disease</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>3/28</b> , 19 <b>62</b> , to <b>4/23</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>4/22</b> , 19 <b>62</b> , and that death occurred <b>9:10 AM</b> from the causes and on the date stated above. 22a. SIGNATURE <b>Thomas F. Lewis</b> M.D. 22b. DATE SIGNED <b>APR 26 1962</b> 22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. LEWIS</b> 22d. ADDRESS <b>WASHINGTON &amp; CUMBERLAND STS., CUMBERLAND, MD.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-26-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		23d. LOCATION (City, town or county) (State) <b>Points, W. Va.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>APR 26 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

04113

CERTIFICATE OF DEATH

10017

ALLIANCE

WEST ALBANY

ALLIANCE

CORRECTION

36 DAYS

CORRECTION

211 ELLER STREET

MEMORIAL HOSPITAL

REINERSON

BESSIE

SEPT. 10, 1914

WHITE

ELMA BARON

JOHN BARR

MEMORIAL HOSPITAL

SEPT. 10, 1914

*Handwritten notes in cursive script, mostly illegible due to fading and bleed-through.*

*Handwritten notes in cursive script, mostly illegible due to fading and bleed-through.*

X

THOMAS T. LEWIS

WASHINGTON & LINDSEY STS. (N. CORNER)

*Handwritten notes at the bottom of the page, including "LAWSON, F. W." and "LAWSON, F. W.".*



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04018

04014

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>54 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lawrence</b> Middle <b>Anthony</b> Last <b>Hewitt</b>				4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1907</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months <b>54</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Francis Hewitt</b>				
14. MOTHER'S MAIDEN NAME <b>Bernadette Mathews</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				
16. SOCIAL SECURITY NO. <b>705-05-4424</b>			17. INFORMANT <b>Mrs. Lawrence Hewitt, Cumberland, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> (c) <b>---</b>						INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>April 11, 1962</b>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>R 9 Cumberland, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 14, 1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	22d. LOCATION (City, town, or country) (State) <b>Cumberland, Md.</b>				
23. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>APR 13 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thane</b>		

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*Handwritten signature*

APR 11, 1963  
H. G. Corporation, Inc.

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04019

CERTIFICATE OF DEATH

04015

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Alleganey</u> <u>MARYLAND</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Alleganey</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>43 Westernport</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>117 Kalbaugh St.</u>		d. STREET ADDRESS <u>117 Kalbaugh</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary M. Hines</u>		<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 17, 1884</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Piedmont, W.Va.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas M. Hines</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Lowry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>314-32-3398</u>	
17. INFORMANT <u>Mrs. Mildred Laughlin, Westernport, Md.</u>		Address <u>  </u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Carcinoma of stomach</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>151X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral vascular accident</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>March 13, 1962</u> to <u>April 14, 1962</u> that (I) <u>(no)</u> last saw the deceased alive on <u>April 13, 1962</u> and that death occurred at <u>12:00 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Rowert W. Bess, M.D.</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>Rowert W. Bess, M.D.</u>		22d. ADDRESS <u>Byon** Jones St. Piedmont, W.Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/16/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Westernport, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Lock</u>		25a. REC'D BY REGISTRAR DATE <u>APR 16 '62</u>	
ADDRESS <u>Piedmont, W.Va.</u>		25b. REGISTRAR'S SIGNATURE <u>W. J. Lock</u>	

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TO HOSPITAL. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04020

## CERTIFICATE OF DEATH

04016

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1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		c. LENGTH OF STAY IN lb <b>17 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 217 S. ALLEGANY STREET</b>		d. STREET ADDRESS <b>1 CUMBERLAND, MD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JEANNIE</b>		First <b>E</b>		Middle <b>HOOVER</b>		Last <b>HOOPER</b>		4. DATE OF DEATH Month <b>APRIL</b>		Day <b>22</b>		Year <b>1962</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 19, 1888</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>KEYSER, WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>									
13. FATHER'S NAME <b>WALTER LOWERY</b>		14. MOTHER'S MAIDEN NAME <b>AURILLA WEAVER</b>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>		Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1977X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinomatosis</b>		INTERVAL BETWEEN ONSET AND DEATH													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>4/5</b> 19 <b>62</b> to <b>4/22</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>4/22</b> 19 <b>62</b> , and that death occurred at <b>9:30 P.M.</b> the causes and on the date stated above.															
22a. SIGNATURE <b>Leo H. Seyge</b>		M.D. <b>DR. LEO LEY</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/22/62</b>									
22c. PHYSICIAN'S NAME (Type) <b>DR. LEO LEY</b>				22d. ADDRESS <b>456 N. CENTER ST. CUMBERLAND, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 25, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) <b>CUMBERLAND, MD.</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 26 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>									

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ALBANY

CO. B. 101  
MEMORIAL HOSPITAL  
DURHAM, N. C.

SAT. 2. ALBANY STREET

MALE  
WHITE  
AUGUST 19, 1930

KEYSER, WEST VIRGINIA

WALTER LOWERY

ANITA MEYER

MEMORIAL HOSPITAL, DURHAM, N. C.

9:30 P.M.

DO. 101

DO. 101

DURHAM, N. C.

DO. 101



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
04021 CERTIFICATE OF DEATH 04017															
1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>			c. LENGTH OF STAY IN lb <u>2 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22. FROSTBURG,</u>			d. STREET ADDRESS <u>1 97 BROADWAY</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES S HORNE, JR</u>					4. DATE OF DEATH Month Day Year <u>4 19 62</u>										
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/12/54</u>		9. AGE (In years last birthday) yrs. Months Days <u>7 7 14</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>CHARLES HORNE</u>					14. MOTHER'S MAIDEN NAME <u>FAYE COOK</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <u>CHART</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>POST-TONSILLECTOMY HEMORRHAGE</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>1/2 HRS</u> <u>10 HRS</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>620</u>		(County) <u>ALLEGANY</u>		(State) <u>MARYLAND</u>					
21. I certify that (I) (this <del>hospital</del> ) attended the deceased from <u>APRIL 13, 1962</u> to <u>APRIL 14, 1962</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>APRIL 14, 1962</u> , and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above.										22a. SIGNATURE <u>A. Bauer</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>APRIL 14, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. BAUER</u>					22d. ADDRESS <u>CUMBERLAND MD.</u>										
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 18-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ALMA CEMETERY</u>			23d. LOCATION (City, town or county) <u>ALMA, KANSAS</u>			(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Duxat</u>					ADDRESS <u>Frostburg, Md</u>		25a. REC'D BY REGISTRAR DATE <u>APR 17 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinas</u>						

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04018

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oldtown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oldtown, Maryland</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>Oldtown, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Home, Oldtown, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Alma Fay Hose</b>				4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 9, 1911</b>	
9. AGE (In years last birthday) <b>50 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bank cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Savings Cumberland Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Meyersdale, Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>William West</b>			
14. MOTHER'S MAIDEN NAME <b>Emma Bittner</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>214-07-4645</b>				17. INFORMANT <b>Jonah Hose</b> Address <b>Oldtown, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b>							
DUE TO (b) <b>CORONARY SCLEROSIS WITH THROMBOSIS</b>							
DUE TO (c) <b>-----</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 27, 1962</b>			
Address (Street, city, town, or county) <b>Cumberland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/29/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Cumberland Maryland</b>	
23. FUNERAL DIRECTOR <b>John J. Hafer Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 1 '62</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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Revised Edition

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04023											
04019											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>				c. LENGTH OF STAY IN 1b <b>LIFETIME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 FROSTBURG,</b>				d. STREET ADDRESS <b>1 145 WOOD STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>145 WOOD STREET</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>RUSSELL</b> <b>HOSKEN</b>						4. DATE OF DEATH <b>APRIL 30TH, 19 62</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 8TH, 1878</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. PAINTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PAINTING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE HOSKEN</b>						14. MOTHER'S MAIDEN NAME <b>HANNAH KEAR</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NONE</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. MARGARET HOSKEN,</b>		Address <b>145 WOOD STREET, FROSTBURG, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Apr 30, 1962 to Apr 30, 1962</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 30, 1962</b> to <b>Apr 30, 1962</b> that (I) (we) last saw the deceased alive on <b>Apr 30, 1962</b> and that death occurred <b>12:15 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>W. O. McLane</b>						M.D. <b>11</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 2 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLane,</b>						22d. ADDRESS <b>167 E. MAIN ST., FROSTBURG, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-3-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'BG. MEMORIAL PARK</b>				23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. R. Durst</b>						ADDRESS <b>FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>MAY 3 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
DATE: [Illegible]  
BY: [Illegible]  
TO: [Illegible]  
FROM: [Illegible]  
[Illegible text follows, including a large handwritten signature and various administrative markings.]

(1)

[Illegible text continues, including a large handwritten signature and various administrative markings.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04024

04020

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		d. STREET ADDRESS <b>19 FAIRVIEW ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ANNA</b> Middle <b>MORGAN</b> Last <b>JAMES</b>		<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>29TH</b> Year <b>1962</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>MAY 25TH, 1905</b>
<b>9. AGE</b> (In years last birthday) <b>56 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>JOHN W. MORGAN</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>JANE KNEPP</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>214-0700313</b>	
<b>17. INFORMANT</b> <b>THOS. J. JAMES, 99 BOWERY ST., F'BG. MD.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>416X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Coronary insufficiency</b> (c) <b>Rheumatic Heart Disease</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	
<b>20c. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20e. (City or town)</b> <b>FROSTBURG</b>		<b>20f. (County)</b> <b>ALLEGANY</b>	
<b>20g. (State)</b> <b>MARYLAND</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from 4-27, 1962, to 4-29, 1962, that (I) (we) last saw the deceased alive on 4-29, 1962, and that death occurred at 7 P.M., from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>H. C. Diehl</b>		<b>22b. DATE SIGNED</b> <b>5-1-62</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>H. C. DIEHL,</b>		<b>22d. ADDRESS</b> <b>39 W. MAIN ST., FROSTBURG, MD.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>5-2-62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>F'BG. MEMORIAL PARK</b>		<b>23d. LOCATION (City, town or county)</b> <b>FROSTBURG, MD.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>L. R. Durr</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 3 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. House</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04025

04021

1. PLACE OF DEATH a. COUNTY <b>MDR ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>7 HRS. 25 MIN.</b>	
d. NAME OF HOME OR INSTITUTION (If in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>RT. #4, OLDTOWN ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES E. JONES</b>		4. DATE OF DEATH <b>APRIL 10, 1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-6-1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MOOREFIELD, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>HENRY JONES</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE MILLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Art Sckr CVD</b> DUE TO <b>Advanced Age</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Advanced Age</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4/3/62</b>		20f. (City or town) (County) (State) <b>Cumby Rd. Alleg. Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4/10/62</b> to <b>4/10/62</b> , 1962, that (I) (one) last saw the deceased alive on <b>4/10/62</b> , 1962, and that death occurred at <b>7:55 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>DR. RICHARD J. WILLIAMS</b>		22b. DATE SIGNED <b>4/11/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. RICHARD J. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 13, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 13 '62</b>	
ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	

04021

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ALLEGANY

MARYLAND

WEST ALLEGANY

CONSUMPTION

7 HRS. 25 MIN.

CONSUMPTION

RT. 11, GLOUCESTER ROAD

MEMORIAL HOSPITAL

10-1-1933

10-1-1933

10-1-1933

SS

1-1-1933

WHITE

WHITE

WOODFIELD, W.V.

EMPLOYED

WHITE MILLER

HENRY JONES

MEMORIAL HOSPITAL - CONSUMPTION

*Handwritten notes and signatures in the middle section.*

*Large handwritten signatures and notes at the bottom of the page.*

122 S. CENTRAL ST., CONSUMPTION, W.V.

DR. RICHARD J. WILLIAMS

CONSUMPTION, W.V.

CONSUMPTION, W.V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04026

## CERTIFICATE OF DEATH

04022

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frostburg,</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg,</u>		d. STREET ADDRESS <u>1 273 Welsh Hill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Jones</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13th</u> , Year <u>1962</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 6th, 1898</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Orderly</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Miners Hospital</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>David Jones</u>				14. MOTHER'S MAIDEN NAME <u>Alice Lewis</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>214-01-3766</u>		17. INFORMANT <u>Mrs. Lottie Jones,</u>		Address <u>273 Welsh Hill, Frostburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Hypertension</u> (e) <u>  </u> (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 1, 1962</u> to <u>Apr 13, 1962</u> , that (I) (we) last saw the deceased alive on <u>Apr 10, 1962</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>W. O. McLane</u>				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Apr 15 1962</u>							
22c. PHYSICIAN'S NAME (Type) <u>W. O. McLane,</u>				" <u>  </u>		22d. ADDRESS <u>167 E. Main Street, Frostburg, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-16-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Frostburg, Md.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. P. Durn</u>				ADDRESS <u>Frostburg, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 17 '62</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. H. H.</u>							

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04027

## CERTIFICATE OF DEATH

04023

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>		c. LENGTH OF STAY IN 1b <b>22 DAYS</b>	
d. NAME OF DECEASED OR INSTITUTION (If in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ETHEL</b> Middle <b>G.</b> Last <b>KESNER</b>		<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>9</b> Year <b>1962</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>4-10-1898</b>
<b>9. AGE</b> (In years last birthday) <b>63</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>ROMNEY, W. VA.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>EHPRAM E. BROWN</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>VIRGINIA DIDAWICK</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
<b>17. INFORMANT</b> <b>Address</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uterine adenocarcinoma - metastatic</b> 174 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between ONSET and DEATH 6 mos</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1953</b> <b>19</b> <b>6:00 P.M.</b> <b>to</b> <b>April 62</b> <b>19</b> <b>that (I) (the) last saw the deceased alive on</b> <b>4/9/62</b> <b>19</b> <b>and that death occurred at</b> <b>6:00 P.M.</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>DR. G. OVERTON HIMMELWRIGHT</b>		<b>22b. DATE SIGNED</b> <b>4/11/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DR. G. OVERTON HIMMELWRIGHT</b>		<b>22d. ADDRESS</b> <b>133 VIRGINIA AVE., CUMBERLAND, MD.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Apr. 12, 1962</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Cumberland, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James F. Scarpelli, Cumberland, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 13 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>			

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JAT 19324-1-10013

12. *Journal of the American Medical Association*, 1990; 263: 1033-1037.

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*Lycopodium obscurum* - Clubmoss

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TO HOSPITAL 8 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04028					04024				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		Allegany			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frostburg, Maryland			b. COUNTY		Allegany		
c. LENGTH OF STAY IN 1b		50 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		22 Frostburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
39 East Main					39 East Main				
3. NAME OF DECEASED (Type or print)									
First		Middle		Last		4. DATE OF DEATH		Month Day Year	
VERA		GETHA		KINNISON		April		24th 19 62	
5. SEX									
F		W		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
				8-10-1888		73 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (County & State, or foreign country)				
Alteration Seamstress Apparel Shop					Dawson, Pa.				
10b. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY?				
Womens					U.S.A.				
13. FATHER'S NAME									
Joseph Kinnison					14. MOTHER'S MAIDEN NAME				
Dora Snyder					York.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)									
NO					Garden City, L.I. New York.				
16. SOCIAL SECURITY NO.									
213-10-9729					Mrs. Paul D. Eddy, 55 Brompton Road,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					INTERVAL BETWEEN ONSET AND DEATH				
4-4-2x DUE TO Cardio-Vascular Renal Disease					Several years				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1958, 19 to Apr 24, 1962, that (I) (we) last saw the deceased alive on Apr 13, 1962, and that death occurred at 11:00 AM, from the causes and on the date stated above.									
22a. SIGNATURE Womc Lane M.D.					22b. DATE SIGNED Apr 25 1962				
22c. PHYSICIAN'S NAME (Type) Womc Lane MD					22d. ADDRESS Frostburg Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 4-27-62				
23c. NAME OF CEMETERY OR CREMATORY Dawson Cemetery					23d. LOCATION (City, town or county) (State) Dawson Pa.				
24. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montesano					25a. REC'D BY REGISTRAR APR 30 '62				
Hafer Funeral Home 23 E. Main, Frostburg, Md.					25b. REGISTRAR'S SIGNATURE Arthur L. Kraus				

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CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>✓</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Melbourne, Fla.</b>				48X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>						d. STREET ADDRESS <b>321 Primrose Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dawn Hollen Mohler Koelz</b>						4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>19 62</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>July 31, 1882</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Keyser, W.Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David W. Mohler</b>						14. MOTHER'S MAIDEN NAME <b>Lucy Wood</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Ronald Screen, Cumberland, Md.</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>422.1</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO <b>Arteriosclerotic Cardiovascular Disease---</b> (c)										INTERVAL BETWEEN ONSET AND DEATH <b>2-3 Day</b> <b>---</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of Right Hip</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in Bathroom</b>							
20c. TIME OF INJURY Month, Day, Year <b>11:30 p.m. Mar. 29, 1962</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Cumberland, Alleg. Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S SIGNATURE <b>Benedict Skitarelic</b> M.D. DATE SIGNED <b>April 22, 1962</b> NAME (Type) <b>BENEDICT SKITARELIC; M.D.</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Apr. 24, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park, Cumberland, Md.</b>				22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						24a. REC'D BY REGISTRAR DATE <b>APR 25 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

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Submitted Material



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 be retained by the hospital or attending physician.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04030

04026

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 HOUR 35 min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>510 A ST.</b>	
3. NAME OF DECEASED (Type or print) <b>AMANDA JANE LAKIN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>19 62</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 20, 1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) yrs. <b>85</b>
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Dittlow</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO <b>coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>coronary sclerosis</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>8</b> <b>3</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/26</b> to <b>4/26</b> , 19 <b>62</b> and that death occurred at <b>4/26</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Elizabeth Brings</b>		22b. DATE SIGNED <b>4/27</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. G. BRINGS</b>		22d. ADDRESS <b>55 GREENE ST. Cumberland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/28/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cem</b>	23d. LOCATION (City, town or county) (State) <b>Boonsboro Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumb Md</b>		25a. REC'D BY REGISTRAR <b>MAY 1 '62</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

1080

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*[Faint, illegible handwritten text, possibly a letter or document, covering the lower half of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04031

## CERTIFICATE OF DEATH

04027

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN b <b>26 HRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b> d. STREET ADDRESS <b>ALGONQUIN HOTEL, Wash. St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ARON LAZARUS</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>APRIL 11 19 62</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>OCT. 27, 1884</b> <b>77</b> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Realtor,</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Real Estate</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>LITHUANIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>SOLOMON LAZARUS</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>DORA FEINSTEIN</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-10-6959</b>	
<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL</b>		<b>Address</b> <b>CUMBERLAND, MD.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</b> <b>Acute left ventricular failure</b> <b>434.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Coronary arteriosclerosis, myocardial fibrosis.</b> (c) <b>Coronary insufficiency</b> <b>Left ventricular hypertrophy</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>27 hours</b> <b>???</b> <b>2 1/2 months</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Diabetes mellitus, substernal thyroid adenoma without hyperthyroidism</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from Feb. 25, 1962, to Apr. 11, 1962, that (I) (we) last saw the deceased alive on April 11, 1962, and that death occurred at 10:25 A.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <i>Samuel M. Jacobson</i> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>SAMUEL M. JACOBSON</b>		<b>22b. DATE SIGNED</b> <b>4/12/62</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>50 PERSHING ST., CUMBERLAND, MD.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/13/62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>East View Cem.</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Cumberland, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles L. George</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 16 '62</b>	
<b>ADDRESS</b> <b>Cumberland, Md.</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Harris</i>	



ALLEGANY

WYOMING

ALLEGANY

CHESLENDEN

ST. HENRY

CHESLENDEN

MEMORIAL HOSPITAL

ALLEGANY HOSPITAL

FROM

DISBURS

APRIL 11

NAME AND WHITE

COT. ST. 1324

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U.S.A.

SOLD ON LARABIS

BORN FELICITY

11-10-32

MEMORIAL HOSPITAL

CHESLENDEN, W.

Route 1 to Cheslelden, W.

Cheslelden, W. (Cheslelden, W.)

Cheslelden, W. (Cheslelden, W.)

Cheslelden, W. (Cheslelden, W.)

APR. 11, 1932

APR. 11, 1932

11/1

20 FLEMING ST., CHESLENDEN, W.

CHARLES L. JACOBSON

11/1

11/1

Charles L. Jacobson, Cheslelden, W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04032

## CERTIFICATE OF DEATH

04028

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 FROSTBURG</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>26 DEPOT STREET</b>		d. STREET ADDRESS <b>26 DEPOT STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>ADA LOGSDON</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>apr 27 1962</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>OCT. 17TH, 1878</b>
<b>9. AGE</b> (In years last birthday) <b>83</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>JOHN G. DEFFENBAUGH</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>JANE HITCHINS</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> Address <b>MISS ALMA LOGSDON, 26 DEPOT ROAD, F.B.G. MD.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Colon</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Sept 1861</b> <b>to</b> <b>Apr 27, 1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Apr 26, 1962</b> <b>and that death occurred at</b> <b>5:20 P.M.</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Wm. Lane</b> M.D.		<b>22b. DATE SIGNED</b> <b>Apr 27 62</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Wm. Lane MD</b>		<b>22d. ADDRESS</b> <b>Frostburg Md</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>4-30-62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>F.B.G. MEMORIAL PARK</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>FROSTBURG, MD.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. R. Burst</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAY 2 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kime</b>			

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STATE OF OHIO

IN SENATE,  
January 10, 1902.  
REPORT  
OF THE  
COMMISSIONER OF THE  
BUREAU OF REVENUE,  
FOR THE YEAR  
ENDING DECEMBER 31, 1901.  
COLUMBUS, OHIO:  
THE STATE PRINTING OFFICE,  
1902.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04029											
1. PLACE OF DEATH e. COUNTY <u>Allegany</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>65 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				d. STREET ADDRESS <u>1 526 Montreal Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>526 Montreal Ave.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Rosette</u> Middle <u>L.</u> Last <u>Long</u>						4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 21, 1894</u>		9. AGE (In years last birthday) <u>68 yrs.</u>		IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>		11. BIRTHPLACE (State or foreign country) <u>Elk Garden, W. Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William H. Long</u>						14. MOTHER'S MAIDEN NAME <u>Nancy C. Mc Ginnis</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>    </u>		17. INFORMANT Address <u>Ralph Long, Cumberland, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u>										INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u>										---	
cause, stating the underlying cause last. (c) <u>    </u>										---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
18a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				18b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>    </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>    </u>		(County) <u>    </u> (State) <u>    </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
21. ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>Apr. 6, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or country) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR ADDRESS <u>James F. Scarpelli, Cumberland, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>APR 5 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Frank</u>			

01033

01033

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RP Cumberland, Md

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04034

04030

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>317 INDEPENDENT STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>WILLIAM N. MACKERT</b>		<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>8</b> Year <b>1962</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3-10-1879</b>
<b>9. AGE</b> (In years last birthday) <b>83</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED WATCHMAN</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME</b> <b>AUGUST M. MACKERT (D)</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>CATHERINE GRELLER (D)</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214 05 7742</b>	
<b>17. INFORMANT</b> <b>PT'S CHART SACRED HEART HOSPITAL</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Carcinomatosis</b> DUE TO <b>199X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arteriosclerosis</b>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from 3/12, 1962, to 4/8, 1962, that (I) (we) last saw the deceased alive on 4/8, 1962, and that death occurred at 6 P.M., from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Dr. L. L. Lew</b>		<b>22b. DATE SIGNED</b> <b>4/9/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DR. L. L. LEW</b>		<b>22d. ADDRESS</b> <b>456 N. Center St.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>4/11/1962</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ST. PETER &amp; PAUL CEMETERY</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>CUMBERLAND, MD.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>BYRON KIGHT</b>		<b>25a. REC'D BY REGISTRAR</b> <b>APR 11 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kinn</b>			

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CENTRAL ST. OF HEALTH

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WEST VIRGINIA

ALLEGANY

SPRINGFIELD

25 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

APRIL

MARTIN

LUTHER

FEBRUARY 11, 1901

WHITE

THREE CHURCHES, W. V.

SARAH KING

JESSE WHITE

MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEMORIAL HOSPITAL, WEST VIRGINIA

MEMORIAL HOSPITAL, WEST VIRGINIA

APRIL 11, 1901

APRIL 11, 1901

50 FARMER ST., CUMBERLAND, MD.

DR. J. M. JACOBSON



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>16 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Theodore Martin</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 31, 1919</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Preparation</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Co.</b>	9. AGE (In years last birthday) <b>43</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Points, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hamilton T. Martin.</b>		14. MOTHER'S NAME <b>Minnie C. Saville</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give year or dates of service) <b>War II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. William T. Martin, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Contusions of Brain, Intracranial Hemorrhage</b> DUE TO (b) <b>Skull Fracture</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>45 Hours</b> <b>45 Hours</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Automobile Accident</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>4:00</b> <b>p.m.</b> <b>April 15 19 62</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 40 West of Cumberland, Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. LOCATION (City, town, or country) (State) <b>Cumberland, Md.</b>	
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		DATE SIGNED <b>April 17, 1962</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 20, 1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 23 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

14002

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04037 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04033

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>02 Cumberland, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>318 Piedmont Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Clyde</b> Last <b>McCleary</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/12/1882</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired U. S. Post Office employee</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>79 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Gettysburg, Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William McCleary</b>				14. MOTHER'S MAIDEN NAME <b>Emma Ballinger</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes, Spanish American War</b>				16. SOCIAL SECURITY NO. <b>579-32-4489</b>			
17. INFORMANT <b>Mrs. Ethel McCleary</b>				Address <b>318 Piedmont Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>-----</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 2-3 Hrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4/17/62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>				22d. LOCATION (City, town, or country) (State) <b>Cumberland, Maryland</b>			
23. FUNERAL DIRECTOR <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>APR 18 '62</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hafer</b>			

MEDICAL CERTIFICATION

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*Handwritten signature*

Benjamin Franklin, M.D.

John J. Baker, Secretary

April 15, 1902

Dr. J. H. Gurnea, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04038

04034

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY in lb <b>7/16/1960</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LaVale</b>	
f. STREET ADDRESS <b>Fisher Apartments</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>M.</b> Last <b>Meyers</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/8/1896</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Mt. Savage, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Daniel Orndoff</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Festerman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b> <b>None</b> <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O. Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, Chn. Degeneration,</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerosis, &amp; cerebral deterioration</b> DUE TO (c) <b>Diabetes Mellitus (Controlled)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/16/60</b> , 19....., to <b>4/12/62</b> , 19....., that (I) (we) last saw the deceased alive on <b>4/12/62</b> , 19....., and that death occurred at <b>A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Lee B. Mathews</b> M.D.		22b. DATE SIGNED <b>4/12/1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/14/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Eckhart Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montross</b>		25a. REC'D BY REGISTRAR <b>APR 17 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. ADDRESS <b>23 E. Main, Frostburg, Md.</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04036

1. PLACE OF DEATH e. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY in 1b <b>4/4/1962</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle Last <b>Nau</b>		4. DATE OF DEATH Month <b>April</b> Day <b>8</b> , Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/14/1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Westernport, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Nau</b>		14. MOTHER'S MAIDEN NAME <b>Mary Shaffer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>P.O.Box 599 Cumberland, Md.</b>	
17. INFORMANT <b>Allegany County Infirmary records.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension, etc. degenerative</b> DUE TO (b) <b>arterio-sclerosis, hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>4/4/1962</b> , 19....., to <b>4/8/1962</b> , 19....., that (I) (we) last saw the deceased alive on <b>4/8/1962</b> , 19....., and that death occurred at <b>8:25 P</b> M, from the causes and on the date stated above. 22e. SIGNATURE <b>Dr. Lee B. Mathews</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b> 22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b> 22b. DATE SIGNED <b>4/9/1962</b> 23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b> 23b. DATE THEREOF <b>April 11, 1962</b> 23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cem.</b> 23d. LOCATION (City, town or county) (State) <b>Westernport, Maryland</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>W. B. Boal</b> ADDRESS <b>Westernport, Maryland</b> 25a. REC'D BY REGISTRAR DATE <b>APR 12 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Carling L. Hume</b>	

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Maryland

Allegany

Westport

4/1/1962

Cumberland

Vine Street

Allegany County Jail

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April

Man

Elizabethtown

TS

6/11/1962

White

Female

Westport, Maryland U. S. A.

None

Harry Sheller

Henry Han

P.O. Box 299

Cumberland, Md.

Allegany County Jail

*[Faint, illegible handwritten notes]*

4/1/1962

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4/1/1962

19 Greene St., Cumberland, Md.

Dr. Joe E. Mathews

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04041

04037

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>15 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>WELLERSBURG</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75X-3</b> d. STREET ADDRESS <b>75X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWIN S O*BAKER</b>		4. DATE OF DEATH Month Day Year <b>APRIL 10 1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 19, 1912</b> 9. AGE (In years last birthday) <b>50 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Kelly Springfield Tire Manufacture</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WELLERSBURG, PENNA.</b>	
13. FATHER'S NAME <b>GEORGE O*BAKER</b>		14. MOTHER'S MAIDEN NAME <b>ADA SHAFFER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-4716</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL,</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myelomonocytic leukemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>204-1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/1/62</b> , 19....., to <b>4/10/62</b> , 19....., that (I) (we) last saw the deceased alive on <b>4/10/62</b> , 19....., and that death occurred <b>9:20 A.M.</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>John A. Topper</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>JOHN A. TOPPER</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>HYNDMAN, PENNA.</b>	
22b. DATE SIGNED <b>4/11/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 13, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cooks Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Wellersburg, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Leigler</b> ADDRESS <b>Hyndman, Pa.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 16 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Anthony S. Thomas</b>			

1001

04037

ALLERGY  
COVERLAND  
15 DAYS  
PENNSYLVANIA  
WELLSBURG

EDWIN  
O'BAKER  
APRIL 10 1902  
WHITE  
JANUARY 10, 1912  
50

U.S.A.  
WELLSBURG, PENN.  
GEORGE O'BAKER  
AND SHAFER

WELLSBURG, PA.  
WELLSBURG, PA.  
WELLSBURG, PA.

JOHN A. TORER  
HYDRAULIC, PENN.  
WELLSBURG, PA.  
WELLSBURG, PA.

WELLSBURG, PA.  
WELLSBURG, PA.  
WELLSBURG, PA.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04038

**1**  
**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ALLEGANY</u> <span style="float: right;">b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</span> <u>LA VALE</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>ALLEGANY</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA VALE</u>			
c. LENGTH OF STAY IN 1b <u>40 YEARS</u>				d. STREET ADDRESS <u>997 NATIONAL HIGHWAY</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>997 NATIONAL HIGHWAY</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>CORA M. OGDEN</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>APRIL 2, 1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 16, 1897</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN R. McMULLEN</u>				14. MOTHER'S MAIDEN NAME <u>MARY JORDAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>RAYMOND E. OGDEN</u>	
Address <u>LA VALE, MD.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY SCLEROSIS WITH THROMBOSIS</u> DUE TO (c)							----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>April 2, 1962</u> <u>R9 Cumberland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 5, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ECKART CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ECKART MD.</u>	
23. FUNERAL DIRECTOR <u>BYRON KIGHT</u>				ADDRESS <u>CUMBERLAND, MD.</u>			
24a. REC'D BY REGISTRAR <u>APR 5 '62</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneen</u>			

M

*Emmett J. Butler*

Remondet, Switzerland, S.O.

April 2, 1962

Re: Emmett J. Butler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, if retained by the hospital or attending physician, must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04043

## CERTIFICATE OF DEATH

04039

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>6 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b> d. STREET ADDRESS <b>ALGONQUIN HOTEL, WASHINGTON ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>ELIZABETH S. PEARRE</b>			<b>4. DATE OF DEATH</b> <b>APRIL 1, 1962</b>		
<b>5. SEX</b> <b>FEMALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>JULY 20, 1870</b> <b>9. AGE</b> (In years last birthday) <b>91</b> <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>VIRGINIA</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>HENRY L. SHOUBE</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>EMILY WINFIELD</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			<b>Address</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia &amp; Cerebral Edema</i> 334 X DUE TO <i>Cerebral Arteriosclerosis &amp; small strokes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>4 days</i> <i>6 months</i>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>3-26-1962</b> <b>to</b> <b>4-1-1962</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>3-31-1962</b> , <b>and that death occurred at</b> <b>3:45 AM</b> <b>the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <i>W. F. Doerner, Jr.</i> <b>22b. DATE SIGNED</b>			<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DR. W. F. DOERNER, JR.</b>			<b>22d. ADDRESS</b> <b>414 N. MECHANIC ST., CUMBERLAND, MD.</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>April 3, 1962</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Cumberland Md</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Louis Stein Inc.</i> <b>ADDRESS</b> <b>Cumberland, Md.</b>			<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>APR 5 '62</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Thomas</i>		

04039

CERTIFICATE OF DEATH

04042

ALLIANCE

CHANDLER

ALLIANCE

CUMBERLAND

6 DAYS

CUMBERLAND

LOGGINS HOTEL, WASHINGTON ST.

MEMORIAL HOSPITAL

APRIL 1, 1950

FEARNE

2.

ELIZABETH

JULY 20, 1950

WHITE

U.S.A.

VIRGINIA

EMILY WINGFIELD

HENRY L. SHORPE

MEMORIAL HOSPITAL - CUMBERLAND, MD.

*Obituary - Charles Edwin  
Charles Edwin - small photo*

414 N. MICHIGAN ST., CUMBERLAND, MD.

DR. M. F. DOERNER, JR.

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04044					04040						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>						
c. LENGTH OF STAY IN 1b <b>54 years</b>					d. STREET ADDRESS <b>327 Race Street</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>327 Race Street</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First Middle Last <b>George Walter Poling</b>					Month Day Year <b>April 10 1962</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 23, 1881</b>		9. AGE (In years last birthday) yrs. Months Days <b>80</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Food Products</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Tucker County, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Andrew Poling</b>					14. MOTHER'S MAIDEN NAME <b>Marca Robinson</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>284-03-5132</b>					17. INFORMANT Address <b>Mrs. Ronald Underdonk, Cumberland, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420</b> DUE TO <b>Myocarditis &amp; Decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>June 1958</b> to <b>Apr 10, 1961</b> ; that (I) (we) last saw the deceased alive on <b>Apr 10, 1961</b> , and that death occurred at <b>8:55pm</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Clay E. Durrett</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/12/62</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. Clay E. Durrett, M.D.</b>					22d. ADDRESS <b>236 Virginia Ave., Cumberland, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Apr. 13, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>APR 17 62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>				

MEDICAL CERTIFICATION

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04045

04041

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS <b>Dudley</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>J.</b> Last <b>Powers</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 10, 1906</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>National Electric Corp</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Frostburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Powers</b>		14. MOTHER'S MAIDEN NAME <b>Mary McHugh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>216-07-2680</b>	
17. INFORMANT <b>Mrs. Thomas Powers</b>		Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Thrombosis</b> DUE TO <b>Generalized Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Burger's Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1, 1960</b> to <b>April 27, 1962</b> , that (I) (we) last saw the deceased alive on <b>April 26, 1962</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. R. Miles, Jr.</b> M.D.		22b. DATE SIGNED <b>4.28.62</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. R. MILES, JR., M.D.</b>		22d. ADDRESS <b>LONA CONING MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/30/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		25a. REC'D BY REGISTRAR <b>MAY 1 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04042

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>16 HRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BABY GIRL REYNOLDS</b>		4. DATE OF DEATH <b>4 22 19 62</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 8 4/88/62</b>
9. AGE (In years last birthday) <b>16</b>		10. IF UNDER 1 YEAR Months Days <b>16</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>EDGAR W. REYNOLDS</b>		14. MOTHER'S MAIDEN NAME <b>ALPHA E. PHARES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Spontaneous 26-wks</b> Conditions, if any, which gave rise to immediate cause (b) <b>(marginal) Placenta Previa</b> (c) <b>Sharp Umbilical Cord</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>10:47 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Fuller B. Whitworth M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. FULLER B. WHITWORTH</b>		22d. ADDRESS <b>123 BEDFORD ST. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Crementation</b>		23b. DATE THEREOF <b>4-23-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Hospital</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur E. Thomas</b>		25a. REC'D BY REGISTRAR DATE <b>APR 25 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>			

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TO: HRS

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615 LOUISIANA ST.

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DAY GIRL REYNOLDS

WHITE

ALPHA E. PHILIPS

EDGAR W. REYNOLDS

RECEIVED ROBERTA, CUMBERLAND, ST.

DR. FULLER B. WHITWORTH

157 SOUTH ST. CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04047

04043

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>22</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		d. STREET ADDRESS <b>Mechanic Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>David W. Ritchie</b>		First Middle Last		4. DATE OF DEATH <b>April 3 19 62</b>		Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 20, 1884</b>		9. AGE (In years last birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Ritchie</b>			14. MOTHER'S MAIDEN NAME <b>Martha Love</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. William E. Ritchie</b> <b>Oil City, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>arteriosclerotic and atherosclerotic disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Cerebral <del>vascular</del> accident days</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1962</b> to <b>April 3, 1962</b> that (he) (she) last saw the deceased alive on <b>April 3, 1962</b> and that death occurred at <b>11:4 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John B. Davis</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/3/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D.</b>				22d. ADDRESS <b>2 BROADWAY, FROSTBURG, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 6 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



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Allegany

Marland

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Johnnie Street

Richie

April

October 20, 1947

Lonsconing, Maryland

Archie Love

Mr. William E. Ritchie

"Son"

Old City, Pa.

01043

Allegany

Prosburn

Johnnie Street

David

White

Retired

David Ritchie

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George Elshorn

Lonsconing, Pa.

Prosburn



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04048  
04044

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> c. LENGTH OF STAY IN lb <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Lonaconing</b> d. STREET ADDRESS <b>West Main Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT REID RITCHIE</b>		4. DATE OF DEATH Month Day Year <b>4/1/1962 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/4/1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>70</b> rs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Lonaconing, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>	
13. FATHER'S NAME <b>David Ritchie</b>		14. MOTHER'S MAIDEN NAME <b>Martha Love</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Alban Bishop, Lonaconing, MD. (Sister)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary emphysema and Bronchectasis</b> 241X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Asthma</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Heart Failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 years 60 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 1962</b> to <b>April 1, 1962</b> , that (I) (we) last saw the deceased alive on <b>April 1, 1962</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William W. Lesh</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>William W. Lesh</b>		22d. ADDRESS <b>90 Main St. Westport Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/3/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Lonaconing, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		25a. REC'D BY REGISTRAR <b>APR 5 '62</b>	
ADDRESS <b>LONACONING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>O. Thos. J. Krantz</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04049  
04045  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN b <b>3 WKS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>WALTER</b> Last <b>RIZER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>8</b> Year <b>1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 26, 1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	9. AGE (In years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM RIZER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH WILLIAMS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>213-10-9860</b>	
17. INFORMANT <b>MRS. MARY RIZER, FROSTBURG, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Rectum</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>154 X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1962</b> to <b>Apr 8, 1962</b> that (I) (we) last saw the deceased alive on <b>Apr 8, 1962</b> and that death occurred at <b>10:00 AM</b> from the causes end on the date stated above.			
22a. SIGNATURE <b>W. O. McLane</b>		22b. DATE SIGNED <b>Apr 9 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLANE, M. D.</b>		22d. ADDRESS <b>167 E. MAIN ST., FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-11-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>F'BG. MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. L. Duret</b>		25a. REC'D BY REGISTRAR <b>Arthur L. Harris</b>	
ADDRESS <b>FROSTBURG, MD.</b>		DATE <b>APR 12 '62</b>	

04042

01042

Decommission of *Phidippus*

from 1948 to 1952

1948

1952

1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04050

04046

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> c. LENGTH OF STAY IN 1b <b>30 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b> d. STREET ADDRESS <b>7 Centennial Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>HELENA</b> First <b>MAY</b> Middle <b>ROBESON</b> Last		4. DATE OF DEATH <b>4</b> Month <b>22</b> Day <b>1962</b> Year				
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-06</b>	9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Germany, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Louis Warnick</b>		14. MOTHER'S MAIDEN NAME <b>Ida Jane Bancord</b>		Address <b>Frostburg, Md.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Forrest F. Robeson, 7 Centennial St.,</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>421.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Aortic Stenosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 mo years</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> to <b>Apr 22, 1962</b> that (I) (we) last saw the deceased alive on <b>Apr 19, 1962</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.						
22a. SIGNATURE <b>W O Mc Lane</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Apr 23, 1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>W O Mc Lane</b>		22d. ADDRESS <b>Frostburg Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/24/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Reformed Cemetery, New Germany Md.</b>		23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>Beulah H. Montes</b>		25a. REC'D BY REGISTRAR <b>APR 30 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>		



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04046

CERTIFICATE OF DEATH

Allegany

Allegany

Allegany

Prossing

Prossing

Prossing

Allegany Hospital

Allegany Hospital

HELEN

HELEN

HELEN

OWN HOME

OWN HOME

OWN HOME

John's Wainlock

John's Wainlock

John's Wainlock

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04051

04047

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL FLINTSTONE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>			d. STREET ADDRESS <b>R. D. # 1 Flintstone Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>SPENCER Lee RUBY</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>4</b> Year <b>19 62</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 21, 1897</b>		9. AGE (In years last birthday) <b>64</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE Corp.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PENNA. Elbinsville</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>MARION RUBY (DECEASED)</b>			
14. MOTHER'S MAIDEN NAME <b>MARY ELBIN (DECEASED)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>176-14-7807</b>		17. INFORMANT <b>PATIENT'S CHART</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> 4200 DUE TO (b) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH <b>56 hours</b> <b>unt</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2 April</b> , 19 <b>62</b> , to <b>2 April</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>3 April</b> , 19 <b>62</b> , and that death occurred at <b>11:42</b> AM, from the causes and on the date stated above.					
22a. SIGNATURE <b>L. Michael Glick</b>		M.D.		22b. DATE SIGNED <b>4 April 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. MICHAEL GLICK</b>		22d. ADDRESS <b>124 N. SMALLWOOD CUMBERLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 7, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion <del>Elbin</del> Cemetery</b>	
23d. LOCATION (City, town or county) <b>Elbinsville, Pennsylvania</b>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>		ADDRESS <b>Cumberland, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE APR 9 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04052						04048					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			ALLEGANY			a. STATE			MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			CUMBERLAND			b. COUNTY			ALLEGANY		
c. LENGTH OF STAY IN 1b			5 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			02 CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If applicable, give name and address)						e. IS RESIDENCE ON A FARM?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MEMORIAL HOSPITAL						210 SEYMOUR STREET					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. IS RESIDENCE ON A FARM?		
First Middle Last						Month Day Year			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MATTIE E. RUTHERFORD						APRIL 12 1962					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
FEMALE		WHITE				SEPTEMBER 29, 1874		87 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Practical Nurse				Self Employed				LEXINGTON, VIRGINIA			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
ANDREW JACKSON BROWN						MARTHA ESTALINE SMITH					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.					
no						none					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						17. INFORMANT Address					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						MEMORIAL HOSPITAL, CUMBERLAND, MD.					
420.1 DUE TO						Coronary Occlusion					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						Cerebral + Generalized Arteriosclerosis with Cardioneglect + Arterio Sclerosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH					
Pulmonary Emphysema; Possible Peptic Ulcer						24 hours					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from April 7th, 1962, to April 12th, 1962, that (I) (we) last saw the deceased alive on April 12th, 1962, and that death occurred at 2:31 A.M. from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED			4-14-62		
DR. WYAND F. DOERNER						M.D.					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
DR. WYAND F. DOERNER						414 N. MECHANIC STREET, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		23e. (State)			
Burial		Apr. 14, 1962		Rose Hill Cemetery		Cumberland, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.						DATE APR 17 '62			Arthur L. Evans		

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01018

CERTIFICATE OF DEATH

ALLEGANY

NATURAL

ALLEGANY

CUMBERLAND

5 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

AVENUE

WATSON & SONS

210 SEYLER STREET

WHITE

WHITE

WHITE

WHITE

WHITE

LEXINGTON, VIRGINIA

U. S. A.

ANNE JACKSON BROWN

MARTHA ESTELLE SMITH

MEMORIAL HOSPITAL, CUMBERLAND, MO.

DR. FRED F. COERNE

414 N. MECHANIC STREET, CUMBERLAND, MO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04053

## CERTIFICATE OF DEATH

04049

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY in lb <b>66 DAYS</b>		d. STREET ADDRESS <b>224 GLEASON ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CLAUDE</b> Middle <b>H.</b> Last <b>SIEBERT</b>		<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>4</b> Year <b>1962</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>7-1-1904</b>
<b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk Freight Dept. Railroad</b>		<b>9b. AGE</b> (In years last birthday) <b>57</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND North Branch</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>JOHN L. SIEBERT</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>ANNIE DRNDORFF</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon with general metastases</b> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital)</b> attended the deceased from <b>Feb 1/62</b> to <b>April 4/62</b> and that death occurred at <b>2:00 P.M.</b> on <b>April 4/62</b> and on the date stated above.		<b>22a. SIGNATURE</b> <b>DR. BLANE SCHINDLER</b>	
<b>22b. DATE SIGNED</b> <b>April 5/1962</b>		<b>22c. ADDRESS</b> <b>43 GREENE ST., CUMBERLAND, MD.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4-7-62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Sunset Burial Park</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Cumberland, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James F. Scarpelli Cumberland, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 10 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Anthony S. Thomas</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician and completely filled in. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04054  
04050

Item 8 Film G312 5/1/62 mh

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN b. <b>5 DAYS</b>		d. STREET ADDRESS <b>ROUTE # 4 BOX 90 OLDTOWN ROAD</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FLORENCE E. SMITH</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1893</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>HUNTER GUNN</b>		14. MOTHER'S MARDEN NAME <b>Anah E. Willison</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Art Sch. Cere.</b> <b>422-1</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis</b> (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr - 3 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State) <b>Cumberland Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3/27/62</b> to <b>4/22/62</b> , 19 <b>62</b> , that (I) <b>we</b> last saw the deceased alive on <b>4/22/62</b> , 19 <b>62</b> , and that death occurred <b>6:01 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>DR. R. J. WMS.</b>		22b. DATE SIGNED <b>4/24/62</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>122 S. CENTER STREET, CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>4/24/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>		25a. REC'D BY REGISTRAR <b>APR 26 '62</b>	
ADDRESS <b>Cumb-Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>	

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04055				CERTIFICATE OF DEATH				04052			
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Luke</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Luke</b>				d. STREET ADDRESS <b>111 Cromwell St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>111 Cromwell St.</b>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Mae Stump Smith</b>						4. DATE OF DEATH <b>April 7 19 62</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 30, 1887</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Alleg. Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Stump</b>						14. MOTHER'S MAIDEN NAME <b>Elizabeth Grant</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. (If yes give war or date of service)		17. INFORMANT <b>Robert Smith 111 Luke Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis and Myocardial Degeneration</b> <b>4 4 3 X</b> DUE TO <b>Not specified as Rheumatic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis and Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 10, 1952</b> to <b>April 7, 1962</b> , that (I) (we) last saw the deceased alive on <b>April 6, 1962</b> , and that death occurred at <b>12:15 am</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Paul R. Wilson</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>April 7, 1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson M.D.</b>						22d. ADDRESS <b>Ashfield St. Piedmont, W. Va.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/9/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Westernport Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Fredlock Jr.</b>						25a. REC'D BY REGISTRAR DATE <b>APR 11 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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Allegany

Maryland

Allegany

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111 Cromwell St.

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Jan. 30, 1887

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U.S.A.

Jacob Stamp

Lizabeth Grant

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Robert Smith, Jr. June 1887

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Home-ville

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April 7, 1887

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Antelope St. Richmond, Va.

Antelope St. Richmond, Va.

Antelope St.

Antelope St.

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Richmond, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04056

## CERTIFICATE OF DEATH

Item 9 Film G312 5/1/62 mh

04051

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY in 1b <b>96 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>		d. STREET ADDRESS <b>403 FAYETTE ST.</b>	
3. NAME OF DECEASED (Type or print) <b>MRS. MYRTLE V. SMITH</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/24/00</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND KITZMILLER, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE STEWART</b>		14. MOTHER'S MAIDEN NAME <b>ROSIE HARVEY.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO <b>Carcinoma Stomach</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Hypothyroidism Multiple thrombophlebitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 4/22</b> to <b>4/22</b> , 1962, that (I) (we) last saw the deceased alive on <b>4/22</b> 1962, and that death occurred at <b>10:35 AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>William P. James</b> M.D.	
22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM JAMES</b>		22d. ADDRESS <b>441 N. CENTRE ST. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 24, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PORTER CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>ECKHART, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		25a. REC'D BY REGISTRAR DATE <b>APR 26 '62</b>	
ADDRESS <b>CUMBERLAND, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

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96 DAYS

CONFIDENTIAL

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MEMORIAL AVE.

HTING V. SMITH

MRS. ERYTE

1/24/00

WHITE

WHITE

ROSE HARVEY.

GEORGE STANT

MEMORIAL HOSPITAL, CORPUSCULI, NO.

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*Corpusculi*

*Hypothalamus, white in the middle*

10337

1100

*in color of brown*

DR. WILLIAM JAMES

101 E. 11th St., CORPUSCULI, NO.

CORPUSCULI, NO.

10337



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04057

Reg. Dist. No. 04053

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN lb <b>Lifetime</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>				d. STREET ADDRESS <b>51 Broadway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS</b> First <b>MERVIN</b> Middle <b>STAPLETON</b> Last				4. DATE OF DEATH Month <b>4</b> Day <b>12th</b> Year <b>19 62.</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-12-1896</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rubber Worker (retired) Kelly Springfield Vale Summit, Md.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Co.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Stapleton</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Delaney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>214-05-9702</b>		17. INFORMANT <b>Mrs. Margaret M. Stapleton, 51 Broadway</b> Address <b>Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b> DUE TO <b>825X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CRUSHED CHEST</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>6 Days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>12:40 April 8 19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 36</b>		20f. (City or town) (County) (State) <b>Wright's Crossing, Allegany County, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4-16-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	
				22d. LOCATION (City, town, or county) <b>Cumberland</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montross</b>				24a. REC'D BY REGISTRAR <b>APR 17 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St, Boston		Teacher		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician	
April 15, 1915		10:30 AM		Home		Dr. Smith	
Signature of Medical Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Place of Certificate		Physician	
April 16, 1915		11:00 AM		Office		Dr. Jones	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04054

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS 4 HRS. 14 MIN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>HADDON AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MICHAEL DALE TABLER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>19</b> Year <b>1962</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>APRIL 19, 1962</b>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <b>2 4 14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>	
13. FATHER'S NAME <b>DALE RICHARD TABLER</b>		14. MOTHER'S MAIDEN NAME <b>LUCY M. GOLDIZEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>754.5</b> DUE TO Congenital Heart Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH</b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>CUMBERLAND</b>		20g. (County) <b>MARYLAND</b>		20h. (State) <b>MARYLAND</b>	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19.....; that (I) (we) last saw the deceased alive on.....19....., and that death occurred at..... <b>9:25 A.M.</b> ..... from the causes and on the date stated above.					
22a. SIGNATURE <b>Fuller B. Whitworth M.D.</b>		22b. DATE SIGNED <b>APR 25 '62</b>		22c. PHYSICIAN'S NAME (Type) <b>FULLER B. WHITWORTH</b>	
22d. ADDRESS <b>123 BEDFORD ST., CUMBERLAND, MD.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 21, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) <b>Cumberland, Md.</b>		23e. (State) <b>MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 25 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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CUMBERLAND

MEMORIAL HOSPITAL

MICHAEL

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APRIL

APRIL 19, 1963

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CUMBERLAND, MARYLAND

WHITE

WHITE

LUCY H. GOUTZEN

DALE RICHARD TALLER

CUMBERLAND, MARYLAND

MICHAEL L. KOSTIAL

123 GUYMON ST., CUMBERLAND, MD.

FULLER B. WHITWORTH

James E. Buchanan, C.O. 100, 101

James E. Buchanan, C.O. 100, 101

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

04059

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04055

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Little Orleans, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Little Orleans, Maryland</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>Little Orleans, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Little Orleans, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Milford</b> Last <b>Trail</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/8/1904</b>	
9. AGE (In years last birthday) <b>57 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Belle Grove, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>James Thomas Trail</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Elizabeth Swain</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-12-9721</b>		17. INFORMANT <b>Mrs. Maysel Trail Little Orleans, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC FAILURE</b> 420.1 DUE TO Condilons, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYOCARDIAL INFARCTION, LEFT: OLD</b> DUE TO (c) <b>CORONARY SCLEROSIS</b>				INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac Hypertrophy, Marked</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 5, 1962</b> Address (Street, city, town, or county) <b>R9 Cumberland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/8/1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Piney Plains Meth. Cemerery</b>		22d. LOCATION (City, town, or country) (State) <b>Piney Plains, Maryland</b>	
23. FUNERAL DIRECTOR <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>APR 9 '62</b>			
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			

MEDICAL CERTIFICATION





*Handwritten signature*

BRITISH CONSUL, N.Y.

APRIL 2, 1962

John T. Kelly, Consul, New York

John T. Kelly, Consul, New York



## MEDICAL CERTIFICATION

VR A15 (4)  
15M 7/61

01038

STATE OF NEW YORK

01038



IN SENATE, January 14, 1914.

REPORT OF THE COMMISSIONER OF THE LAND OFFICE.

ALBANY: JAMES B. LEE, STATE PRINTER, 1914.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04061

04057

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>6 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>205 CARROLL STREET</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MAE</b> Middle <b>BELLE</b> Last <b>TRUE</b>		<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>25</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>JULY 27, 1885</b>
<b>9. AGE</b> (In years last birthday) <b>76 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WEST VIRGINIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JEROME WILSON</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>EMMA TICE</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>	
<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Hemiplegia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive &amp; Arteriosclerotic</b> DUE TO (c) <b>Cardio Vascular Disease</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Cardiac Decompensation</b>		<b>INTERVAL BETWEEN ONSET/AND DEATH</b> <b>4/19/62</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>19</b> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>3/26</b> , 19 <b>62</b> to <b>4/25/62</b> ; that (I) (we) last saw the deceased alive on <b>4/24</b> , 19 <b>62</b> , and that death occurred <b>8:25 AM</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Thomas F. Lusby</b> M.D.		<b>22b. DATE SIGNED</b> <b>4/25/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>THOMAS F. LUSBY</b>		<b>22d. ADDRESS</b> <b>125 BEDFORD ST., CUMBERLAND, MD.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Apr. 27, 1962</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Burial Park</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Cumberland, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James F. Scarpelli, Cumberland, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAY 1 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Evans</b>			

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04037

STATE OF OHIO

ALLEGANY

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CUMBERLAND

CUMBERLAND

2 DAYS

MEMORIAL HOSPITAL

205 CARROLL STREET

WHITE

JULY 23, 1935

APRIL

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THE

ST. VIRGINIA

GEORGE WILSON

AND TIO

MEMORIAL HOSPITAL, CUMBERLAND, MD.

THOMAS F. LEBBY

125 HEDDING ST., CUMBERLAND, MD.

ALLEGANY COUNTY, OHIO

JAMES F. GOSWELL, JR.,

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04062

04058

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>5 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOAPITAL</b>			d. STREET ADDRESS <b>1 489 GOETHE ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>PRESTON</b> Middle Last <b>TWIGG</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>2</b> Year <b>19 62</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 16, 1880</b>	9. AGE (In years last birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>Albert Twigg</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Hudson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-10-6837</b>		
17. INFORMANT <b>PATIENT'S CHART</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>420 Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>And Arteriosclerotic Heart Disease</b> <b>Pulmonary Emphysema &amp; Fibrosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b> <b>unknown</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>3/28/62</b> to <b>4/2/62</b> ; that (I) (we) last saw the deceased alive on <b>4/2/62</b> and that death occurred <b>10:58 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>W. Weissman</b>			22b. DATE (SIGNED) <b>4/3/62</b>		
22c. PHYSICIAN'S NAME (Type) <b>SIG. WEISSMAN</b>			22d. ADDRESS <b>54 Greene St Cumberland, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Martin Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Little Orleans, Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b> <b>Cumberland, Maryland</b>			
25a. REC'D BY REGISTRAR <b>DATE APR 9 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04063

04059

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WILLIAMS ROAD, ROUTE 2,</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>R. ALVA B. TWIGG</b>				4. DATE OF DEATH Month Day Year <b>APRIL 12 19 62</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 23, 1874</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANCIS TWIGG</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE GLEICHMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>WILLIAM J. TWIGG, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocarditis - Decompensated</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>6 wks</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 61</b> to <b>Apr 12 19 62</b> that (I) (we) last saw the deceased alive on <b>Apr 12 19 62</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Clay E. Durrett</b>			22b. DATE SIGNED <b>4/13/62</b>		22c. PHYSICIAN'S NAME (Type) <b>CLAY E. DURRETT, M.D.</b>		
22d. ADDRESS <b>236 VIRGINIA AVE, CUMBERLAND, MD.</b>			22e. ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>APRIL 15, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. HERMAN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>CUMBERLAND, MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>			ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 16 '62</b>		
					25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hump</b>		

00003



CERTIFICATE OF

00002

CHIEF

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FOR STATE HEALTH REPORT  
99  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04064

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04060

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart Hospital</b>			d. STREET ADDRESS <b>RD#1 W alley Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Theodore Twigg</b>			4. DATE OF DEATH <b>April 8, 1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1913</b>	9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kelly Springfield</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tires</b>		11. BIRTHPLACE (State or foreign country) <b>Hyndman, Pa.</b>	
13. FATHER'S NAME <b>William Twigg</b>			14. MOTHER'S MAIDEN NAME <b>Ella Minnick</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>206-01-9190</b>		17. INFORMANT <b>Mrs. Helen Twigg, Cumberland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS WITH THROMBOSIS</b> (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>***--</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 8, 1962</b> Address (Street, city, town, or county) <b>Cumberland Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 12, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>	
22d. LOCATION (City, town, or country) <b>Hyndman, Pa.</b>		(State)			
23. FUNERAL DIRECTOR <b>Harvey H. Zeigler</b>			24. REC'D BY REGISTRAR <b>APR 11 '62</b>		
ADDRESS <b>Hyndman, Pa.</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04065 04061											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>62 Cumberland</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>923 Bedford St.</b>						d. STREET ADDRESS <b>923 Bedford St.</b>					
3. NAME OF DECEASED (Type or print) <b>Lucie Z. Wagner</b>						4. DATE OF DEATH <b>April 2, 1962</b>					
5. SEX <b>Female</b>						6. COLOR OR RACE <b>White</b>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <b>October 19, 1881</b>					
9. AGE (In years last birthday) <b>80</b> yrs.						10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>					
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						13. FATHER'S NAME <b>Herbert Wagner</b>					
14. MOTHER'S MAIDEN NAME <b>Margaret Knepp</b>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					
16. SOCIAL SECURITY NO.						17. INFORMANT <b>Address</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROTIC RENAL DISEASE</b> DUE TO cause last. (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>april</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 2, 1962</b> DATE SIGNED Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>						22b. DATE THEREOF <b>3/5/62</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>Beinhauer Funil Home</b>						22d. LOCATION (City, town, or country) (State) <b>Pittsburg Penna.</b>					
23. FUNERAL DIRECTOR <b>Louis Stein Inc.</b>						24a. REC'D BY REGISTRAR <b>DATE</b>					
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>											

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institutional residence, before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>40 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		d. STREET ADDRESS <b>1 39 Elder Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Samuel John Whetzel</b>				4. DATE OF DEATH Month Day Year <b>April 27 19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1901</b>		9. AGE (In years last birthday) <b>61 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Instrument Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Paw Paw, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Whetzel</b>				14. MOTHER'S MAIDEN NAME <b>Hannah</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Mrs. Myrtle Whetzel, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Rupture</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Coronary Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH Minutes Hours Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 27, 1962</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 29, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR   24b. REGISTRAR'S SIGNATURE DATE <b>MAY 1 '62</b> <b>Arthur J. Hines</b>			

MEDICAL CERTIFICATION

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